Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Feb 3, 7, 9, 13, 14, 15, 16, 17, 21, 22, 27, 28, 29, Mar 1, 2, 6, 2012	2012_036126_0003	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

LINDA HARKINS (126), CAROLE BARIL (150), COLETTE ASSELIN (134)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Nurse, Registered Nurses(RN), Registered Practical Nurses(RPN), Personal Support Workers(PSW), Dietitian, Housekeeping/Maintenance Manager, Food Service Supervisor(FSS) housekeeping and activity staff, residents and families.

During the course of the inspection, the inspector(s) reviewed residents' health care records, observed care and services provided to residents and reviewed the abuse and restraint policies.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with section 20 (1) and (2) in that, the licensee failed to put in place a written policy to promote zero tolerance of abuse and neglect of residents as per legislative requirements;

The licensee has failed to comply with section 20 (1) (a) in that, the licensee failed to include that abuse and neglect are not to be tolerated in their written policy # HS-1400 on Violence and Harassment Prevention.

The licensee has failed to comply with section 20 (2)(b) of the LTCH Act 2007, in that the content of the policy is not complete as per the requirement.

The Home has a policy # HS-1400 related to Violence and Harassment Prevention Policy and Program for Resident, dated February 2011. This policy does not clearly set out what constitute abuse and neglect.

The licensee has failed to comply with section 20 (2)(c) of the LTCH Act 2007 to provide a program that complies with the regulations, for preventing abuse and neglect as per the following findings:

The licensee has failed to comply with section 20 (2)(d) of the LTCH Act 2007, in that the program does not contain an explanation of the duty under section 24 to make mandatory reports. The policy # HS-1400 Violence and Harassment Prevention Policy and Program for Residents, does not contain an explanation of the duty under section 24 of the Act to make mandatory reports.

The following findings indicate that the licensee did not comply with Section 20(2)(e)(g)(h)of the LTCHA 2007:

The licensee has failed to comply with section 23 (2) of the LTCH Act 2007, in that the licensee did not provide the results of the investigation of an alleged abuse to the Director. The results of the January 2012, resident to resident emotional abuse investigation, was not reported to the Director.

The licensee did not comply with s. 24 (1) of the LTCH Act 2007, in that the licensee did not immediately report the suspicion of resident to resident abuse, resulting in harm or risk of harm to the Director.

In January 2012, there was an incident of resident to resident emotional abuse. The Director was not notified of this incident.

The licensee has failed to comply with O.Reg 79/10, s.96 (a)(b)(c)(d) and (e) in that the licensee's written policy on zero tolerance of abuse is incomplete.

a) The policy # HS-1400 was reviewed, it does not contain any procedures and interventions to assist, support residents who have been allegedly abused or neglected.
b) There are no procedures and interventions specifying how to deal with persons who has abused or neglected the residents.
c) There is no procedures detailing on how to prevent abuse and neglect.
d)The manner in which allegations of abuse and neglect will be investigated is not described in the policy.
e)The policy does not identify training and retraining requirement for all staff.

In January 2012 there is an entry in one identified resident's chart indicating being afraid to be left alone in the room due to roommate behavior. The other identified resident admitted to the behavior. As such, the following areas were not complied with:

The licensee did not comply with section 97 (1) (a) of the O. Reg 79/10, in that the Substitute Decision Maker (SDM) was not notified that one identified resident was allegedly emotionally abused by one other resident.

The licensee did not comply with section 97 (2) of the O.Reg 79/10 in that the resident's SDM was not notified of the

result of the resident to resident emotional abuse investigation.[s.20(2)(e)]

The licensee has failed to comply with O.Reg 79/10 s.104.(2), in that the licensee did not report the incident of alleged abuse to the Director within 10 days.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee did not comply with s. 98 of the O.Reg 79/10, in that the licensee did not immediately report to the police an alleged emotional abuse by one resident toward another, which had resulted in fear.

The police was not immediately notified once staff and management was informed that one identified resident was emotionally abusive toward a roommate because he/she had been keeping him/her awake.

During the Resident Quality Inspection (RQI), the compliance history was reviewed. It was noted that during inspection conducted in May 2011 # 2011_03126_0044, a written notification (WN) was issued and that during inspection conducted in December 2011 # 2011_03126_0005 a voluntary plan of correction (VPC) was issued because the police was not notified as a result of a resident to resident abuse.

The DOC, reported to the inspector that the police was not called in the instance where one identified resident was emotionally abusive toward another resident in January 2012. The DOC indicated that the identified resident was informed that the police would be called if this incident reoccurred.

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.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

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

Findings/Faits saillants :

1. The licensee has failed to comply with section 3 (1)1 of the LTCH Act 2007, in that the licensee failed to ensure that every resident are treated with courtesy and respect.

Two PSWs were interviewed. They were not aware that there were privacy curtains in the tub rooms.

One identified resident had reported to the inspector that when staff give the tub bath, the privacy curtain is not drawn exposing his/her to incoming staff.

The inspector observed the tub room the afternoon of Feb 17, 2012. One other identified resident, was in finishing his/her bath and indicated the curtain had not been drawn during the tub bath.

On February 17, 2012 around 10:15, three Personal Support Workers were heard arguing and yelling about who would be getting the tub chair next. This verbal altercation took place while a resident was finishing his/her bath. The resident was disturbed by the incident. [sec.3(1)1]

The licensee has failed to comply with section 3 (1)4 of the LTCH Act 2007, in that the licensee failed to ensure that every resident has the right to be properly groomed and cared for in a manner consistent with his or her needs.

Inspector 126, observed, one identified resident, seated in a wheelchair that had an offensive urine odor. This occurred just after he/she had been bathed.

One other identified resident was observed to have facial hair on Feb 9, 2012 after a tub bath had been given. This resident's care plan was reviewed and there is an entry indicating the PSW are to remove facial hair.

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 residents are treated with respect and courtesy, that they are groomed and care in a manner that meets their needs and they live in a clean environment, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following subsections:

s. 15. (1) Every licensee of a long-term care home shall ensure that,
(a) there is an organized program of housekeeping for the home;
(b) there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents; and
(c) there is an organized program of maintenance services for the home. 2007, c. 8, s. 15 (1).

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

Findings/Faits saillants :

1. The licensee has failed to comply with section 15 (1) (C) in that the licensee does not have an organized program of maintenance for the home.

The Maintenance Manager, reported to the Inspector that the home has no organized program of maintenance services for bathing equipment and transfer equipment. He reported that the home will fix minor problems with the equipment (i.e.lifts and tub chairs) and have Ontario Medical Supply do the maintenance of the equipment.

Discussion held with the Activity Manager, who confirmed that Ontario Medical Supply keeps a log for repairs done on the residents' equipment but no log is kept for repairs done on the bathing equipment and transfer equipment.

On February 16, 2012 the brakes on the only available tub chair were reported to be malfunctioning by a resident. The Maintenance Manager was aware that the brakes were not working properly since the day before but the chair was used to give baths in the morning of February 17, 2012 even though the brakes had not been repaired. (126,) [sec.15(1)(c)]

2. The licensee has failed to comply with s.15 (2) (a) of the LTCH Act 2007, in that the home, furnishing and equipment are not kept clean and sanitary.

On February 7,2012, the Inspector observed:
two privacy curtains were soiled; 2 unidentified urinals were soiled; 2 individual wall mounted cabinets soiled with dark water stains on both residents' shelves; one bedside table dirty and dusty; one top of the bed side table was dirty and sticky; a medium size dark brown stain behind the resident's lazy boy chair. [s.15(2)(a)]

3. The licensee has failed to comply with s.15 (2)(c) of the LTCH Act 2007, in that the home, furnishings and equipments are not maintained in a safe condition and in good state of repair.

During the Resident Quality Inspection, the Inspectors identified the following areas in poor state of repair:

The call bell mechanism in one bathroom was missing, preventing the resident from calling for assistance; damage on the top surface of the dressers preventing proper cleaning; damage to the top of the bedside table and scraped edge preventing proper cleaning; cord lights over the residents' bed were not accessible; a hole in the bottom corner of left side wall of a bathroom door and closet door; bed side tables were observed to be damaged, the edge of the table scraped; and one drawer had no knob.

Activities room: The edge of the counter top was missing on the left hand side causing possible injury to residents.

East wing
Shower and tub room: the Inspectors observed black marks and paint scrapes up to 40 inches high on the baseboards, walls and doors. The bathroom adjacent to the shower room has patches of plaster not painted. Rust stains were observed on the floor behind the bathtub and the wall closest next to the bathtub was observed to have water damage. The white small cabinet was water damaged and chipped. The rubber strip around the tub bath is damage and detached. The enamel of the bathtub is chipped. The tub chair was observed to be ripped on the edge. Two residents reported to have been caught in the elevated position because the bath chair was not responding to the hand command.

West wing
Shower and tub room: the Inspectors observed a water damaged wall, next to the bath tub; rust stains on the floor behind the bath tub; gaps in the floor surface along the baseboard and at the door entrance of the shower room and holes on the floor next to the bath tub. There are two un-patched holes below the towel bar.

Hallway: the Inspectors observed the West Wing corridor's floor surface bubbled towards the mid end of the corridor more specifically along the door entrance of room 137, this is a possible risk for residents tripping and injury. [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 the licensee has an organized program of maintenance services for the home, that the home, furnishings and equipment are kept clean and sanitary and maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following subsections:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with s. 31 (2) 4 of the LTCH Act 2007 in that the restraining devices were applied without a physician's order.

One identified resident uses two bedrails when in bed and wears a trunk restraint daily and uses a chair that prevents rising. This resident has also an attached tabletop. The health care records were reviewed. There were no current orders for the lapbelt and chair preventing rising.

One other identified resident's plan of care was reviewed and the only indication for restraint was two bedrails, while the resident was observed to be sitting in a wheel chair (w/c) using a table top. This resident was unable to undo the table top. No physician orders were found in the resident's health record.

The licensee has failed to comply with s. 31 (2) (5) of the LTCH Act 2007 in that, the restraining devices were applied without a consent.

The identified resident did not have consent for the use of the table top.(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 the licensee obtains an order and consent for application of all physical restraints, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.
2. An unexpected or sudden death, including a death resulting from an accident or suicide.
3. A resident who is missing for three hours or more.
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s.107 (1) 5, in that the licensee did not immediately inform the Director of an outbreak.

The respiratory outbreak was declared January 27, 2012 and the Director was notified February 2, 2012.

The licensee has failed to comply with O.Reg 79/10 s.107 (3) 4, in that, the licensee did not inform the Director of a resident's transfer to hospital caused by an injury.

In December 2011, one resident, injured his/her lower arm during his/her bath and was transferred to hospital several days later for assessment and treatment of the injury. The Director of Care reported that there was an internal critical incident report completed but that no critical incident report was sent to the Director.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the critical incidents are reported to the Director as per the legislative requirements under r.107(1) as to when to immediately inform the Director and r.107(3) as to inform the Director no later than one business day, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

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
(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 comply with section 129 (1) (b) in that the controlled substances are not stored in a separate, double locked stationary cupboard in a locked area or stored in a separate locked area within the locked medication cart.

One identified resident has an order for benzodiazepines. These controlled substances are not double locked.

The RN, was interviewed and reported that controlled substances are not double locked or stored in a separate locked area.

The RPN was interviewed and reported that one identified resident is on benzodiazepine and that this medication is not double locked.

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 in regards to ensuring that controlled substances are stored in a separate, double locked stationary cupboard in a locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following subsections:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 90 (2) (k), that the water temperature is not monitored once per shift in random locations where residents have access to hot water.The Inspector reviewed the water record temperature for December 2011 and January 2012.

The RN was interviewed and reported that staff are aware of the hot water monitoring procedure.

The "Hot water temperature record" for December 2011, was reviewed. It was observed that the water temperature was not monitored on day shift 21/31 days and on evening shift 31/31 days and on night shift 10/31 days.

The "Hot water temperature record" for January 2012,was reviewed and it was observed that the hot water temperature was not monitored on day shift 7/31 days, on evening shift 30/31 days and on night shift 10/31 days.

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 water temperature is monitored once per shift in random locations where residents have access to hot water, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following subsections:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) an explanation of the duty under section 24 to make mandatory reports;
(e) the long-term care home's procedure for initiating complaints to the licensee;
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints;
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained;
(h) the name and telephone number of the licensee;
(i) an explanation of the measures to be taken in case of fire;
(j) an explanation of evacuation procedures;
(k) copies of the inspection reports from the past two years for the long-term care home;
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years;
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years;
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council;
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council;
(p) an explanation of the protections afforded under section 26; and
(q) any other information provided for in the regulations. 2007, c. 8, ss. 79 (3)

Findings/Faits saillants :

1. The licensee failed to comply with section s.79. (3) (c)(g)(p) of the LTCH Act 2007 in that, the Licensee did not post the following policies:

(c)promote zero tolerance of abuse and neglect of resident
(g)minimize the restraining of resident
(p)whistle-blowing protections related to retaliation

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

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10, s.17 (1) a, in that a resident's call bell is not easily seen and accessible to resident and staff. It was observed that in one identified resident's bathroom, there was no cord attached to the call bell system making it difficult to activate.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10, s.41 in that, the rest routines were not supported and individualized to promote comfort, rest and sleep of a resident.

In February 2012, one identified resident reported to the inspector that staff were heard speaking loudly in the sitting area outside his/her room during the evening shift preventing the resident from sleeping.

The RPN, states that the resident had complained of this. The RPN informed staff during the shift report of the nature of the complaint and reported it to the DOC.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10,s.134(a) in that there is no documentation of resident's response or the effectiveness to an anti-psychotic drug requiring ongoing monitoring.

One identified resident's progress notes were reviewed between January and February 2012. There are several entries indicating an anti-psychotic was administered at the resident's request. There is no indication of the reason why the medication was administered. There is an entry indicating the medication was effective but no indication on how it helped manage the behavior. The resident's monitoring, response and effectiveness of the anti-psychotic is not documented in the progress notes.

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

Specifically failed to comply with the following subsections:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

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

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10, s.35.(1) in that, the licensee did not provide preventive and basic foot care services to ensure comfort and prevent infections.

One identified resident was observed to have long toe nails and confirmed that preventative and basic foot care was not provided.

The licensee has failed to comply with O.Reg 79/10, s.35.(2) in that, the licensee did not ensure that each resident of the home receives fingernail care including the cutting of fingernails.

Several identified residents were observed to have unclean and/or untrimmed nails. [r.35(2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 r. 110 (7) 5,6,7 and 8, in that the licensee failed to document the use of physical restraints.

The "Resident Restraint Record" was reviewed for the month of February 2012 and there is no documentation for the use of the physical restraint for several identified residents.

There is no documentation of the person who applied the device and the time of application. [r.110 (7) 5]

There is no documentation for assessment, reassessment and monitoring, including the residents' response. [r.110 (7) 6]

There is no documentation to indicate the release of the device and no documentation to indicate the repositioning. [r.110 (7) 7]

There is no documentation related the removal of the device.[r.110 (7) 8

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following subsections:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has not complied with section 59 (7) (b), in that the licensee does not convene semi-annual meetings to advise residents' families of the rights to establish a Family Council.

The Activity Director reported that the home has not been convening semi-annual meetings to inform residents' families of their rights to establish a Family Council.

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following subsections:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

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

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

Findings/Faits saillants :

1. The licensee has failed to comply with section 85(3) of the LTCH Act, 2007 in that the licensee does not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

The Activity Director, was interviewed. She reported that the home does not currently have a satisfaction survey and has not been seeking the advice of the Resident's Council in developing a survey.

The Administrator, reported that the home has never done a satisfaction survey for all programs

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WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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).

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

Findings/Faits saillants :

1. The licensee failed to comply with section s. 6 (4)(a) in that the licensee did not ensure that all staff collaborate with each other to provide consistent care to the resident.

One identified resident was assessed in December, 2011 by the Physio Assistant. This resident was assessed to need a wheel chair(w/c) with a table top. Following the assessment, this resident's was in a w/c with a table top, which he/she could not remove on her own.

On February 14, 2012, discussion was held with the RPN and the RN, both reported to the Inspector that they were not made aware by Physio that the table top was to be used as a restraining device. At that time, it was noted that the resident did not have a restraint order or consent for the table top.

This resident was in a w/c with a table top from December 2011 to February 2012 without a physician order. The interdisciplinary staff did not collaborate and with each other to provide consistent care to the resident.

2. The licensee failed to comply with section s. 6 (10) in that one identified resident's care set out in the plan of care was not reviewed and revised when it was not effective.

The DOC reported to inspector #134 that one identified resident's care set out in the plan of care is not effective, that the resident continues to have outbursts and to abuse other residents emotionally. The nursing staff reported that this resident is alert and capable of making decisions. During the RQI, the inspector observed this resident responding impulsively to other residents' comments and was observed yelling at a confused and frail resident.

The RN indicated this resident has socially inappropriate and verbally aggressive behaviors.

The resident's plan of care was reviewed. There are several entries specifying that this resident is socially inappropriate, will rummage through other residents' belongings and is disruptive as well as being verbally abusive toward residents. There is entry indicating her behavior requires to be monitored 24 hours a day. In July 2011, there is a note in the plan of care to refer the resident to a psychiatrist. No action or measures were taken since July 2011 to refer this resident to a psychiatrist.

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

CORRECTED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 15.	CO #001	2011_054133_0031	126

Issued on this 7th day of March, 2012

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

L Hawkins (126) Colette Asselin (134) (150)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LINDA HARKINS (126), CAROLE BARIL (150), COLETTE ASSELIN (134)
Inspection No. / No de l'inspection :	2012_036126_0003
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Date of Inspection / Date de l'inspection :	Feb 3, 7, 9, 13, 14, 15, 16, 17, 21, 22, 27, 28, 29, Mar 1, 2, 6, 2012
Licensee / Titulaire de permis :	1663432 ONTARIO LTD. 2212 GLADWIN CRESCENT, UNIT A-9, SUITE 200, OTTAWA, ON, K1B-5N1
LTC Home / Foyer de SLD :	MANOIR MAROCHEL 949 MONTREAL ROAD, OTTAWA, ON, K1K-0S6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PIERRE BERNIER

To 1663432 ONTARIO LTD., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure action is taken to develop a written policy to promote zero tolerance of abuse and neglect of residents that includes all requirement under section 20 (1) and (2) and ensure that the policy is complied with. This plan must include training for all staff and volunteers.

This plan must be submitted in writing to Inspector Linda Harkins at 347 Preston Street, 4th floor, Ottawa ON K1S 3J4 or by fax at 613-569-9670 on or before March 16, 2012.

Grounds / Motifs :

1. 1. The licensee has failed to comply with section 20 (1) and (2) in that, the licensee failed to put in place a written policy to promote zero tolerance of abuse and neglect of residents as per legislative requirements;

The licensee has failed to comply with section 20 (1) (a) in that, the licensee failed to include that abuse and neglect are not to be tolerated in their written policy # HS-1400 on Violence and Harassment Prevention.

The licensee has failed to comply with section 20 (2)(b) of the LTCH Act 2007, in that the content of the policy is not complete as per the requirement.

The Home has a policy # HS-1400 related to Violence and Harassment Prevention Policy and Program for Resident, dated February 2011. This policy does not clearly set out what constitute abuse and neglect.

The licensee has failed to comply with section 20 (2)(c) of the LTCH Act 2007 to provide a program that complies with the regulations, for preventing abuse and neglect as per the following findings:

The licensee has failed to comply with section 20 (2)(d) of the LTCH Act 2007, in that the program does not contain an explanation of the duty under section 24 to make mandatory reports. The policy # HS-1400 Violence and Harassment Prevention Policy and Program for Residents, does not contain an explanation of the duty under section 24 of the Act to make mandatory reports.

The following findings indicate that the licensee did not comply with Section 20(2)(e)(g)(h)of the LTCHA 2007:

The licensee has failed to comply with section 23 (2) of the LTCH Act 2007, in that the licensee did not provide the results of the investigation of an alleged abuse to the Director. The results of January 25, 2012, resident to resident emotional abuse investigation, was not reported to the Director.

The licensee did not comply with s. 24 (1) of the LTCH Act 2007, in that the licensee did not immediately report the suspicion of resident to resident abuse, resulting in harm or risk of harm to the Director.

In January 2012, there was an incident of resident to resident emotional abuse. The Director was not notified of this incident.

The licensee has failed to comply with O.Reg 79/10, s.96 (a)(b)(c)(d) and (e) in that the licensee's written policy on zero tolerance of abuse is incomplete.

a) The policy # HS-1400 was reviewed, it does not contain any procedures and interventions to assist, support residents who have been allegedly abused or neglected.
b) There are no procedures and interventions specifying how to deal with persons who has abused or neglected the residents.
c) There is no procedures detailing on how to prevent abuse and neglect.
d)The manner in which allegations of abuse and neglect will be investigated is not described in the policy.
e)The policy does not identify training and retraining requirement for all staff.

In January 2012 there is an entry in one identified resident's chart indicating being afraid to be left alone in the room due to the roommate's behavior. The other identified resident admitted to the behavior. As such, the following areas were not complied with:

The licensee did not comply with section 97 (1) (a) of the O. Reg 79/10, in that the Substitute Decision Maker (SDM) was not notified that one identified resident was allegedly emotionally abused by one other resident.

The licensee did not comply with section 97 (2) of the O.Reg 79/10 in that the resident's SDM was not notified of the result of the resident to resident emotional abuse investigation.[s.20(2)(e)]

The licensee has failed to comply with O.Reg 79/10 s.104.(2), in that the licensee did not report the incident of alleged abuse to the Director within 10 days. (134)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 06, 2012

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Order / Ordre :

The licensee will ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident to achieve compliance with requirement O. Reg 79/10 section 98.

Grounds / Motifs :

1. 1. The licensee did not comply with s. 98 of the O.Reg 79/10, in that the licensee did not immediately report to the police an alleged emotional abuse by one resident toward another, which had resulted in fear.

The police was not immediately notified once staff and management was informed that one identified resident was emotionally abusive toward a roommate because he/she had been keeping him/her awake.

During the Resident Quality Inspection (RQI), the compliance history was reviewed. It was noted that during inspection conducted in May 2011 # 2011_03126_0044, a written notification (WN) was issued and that during inspection conducted in December 2011 # 2011_03126_0005 a voluntary plan of correction (VPC) was issued because the police was not notified as a result of a resident to resident abuse.

The DOC, reported to the inspector that the police was not called in the instance where one identified resident was emotionally abusive toward another resident in January 2012. The DOC indicated that the identified resident was informed that the police would be called if this incident reoccurred. (134)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 06, 2012

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent 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

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

and the

Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
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 6th day of March, 2012

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LINDA HARKINS

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