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

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

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jun 18, 2015;	2015_191107_0001 (A2)	H-001831-15	Resident Quality Inspection

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD SUITE 205 TORONTO ON M6A 1J6

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

COOKSVILLE CARE CENTRE
55 THE QUEENSWAY WEST MISSISSAUGA ON L5B 1B5

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

Ministry of Health and Long-Term Care

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

MICHELLE WARRENER (107) - (A2)

Amended Inspection Summary/Résumé de l’inspection modifié
Compliance Order #005, Regulation s. 19, Compliance date revised from April 30, 2015 to May 15, 2015.

Issued on this 18 day of June 2015 (A2)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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MICHELLE WARRENER (107) - (A2)

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): January 19, 20, 21, 22, 23, 26, 27, 28, 29, 30, February 3, 4, 5, 2015

The following inspections were completed concurrently with this Resident Quality Inspection:

Complaint Inspections H-001203-14, H-001490-14, H-001027-14 (partial), H-001157-14 (partial)

Critical Incident H-001733-14

Follow up to Orders:

H-001236-14 - s. 19(1)

H-001238-14 - r. 72(3)

H-001239-14 - r. 73(1)

H-001240-14 - r. 8(1)

H-001241-14 - r. 72(2)

During the course of the inspection, the inspector(s) spoke with Residents,

family members of residents, members of the Resident and Family Councils, the Administrator, Director of Nursing, Clinical Director of Nursing, Skin Care and Wound Coordinator, Social Worker, Registered Dietitian, Dietary Manager, Environmental Manager, Business Manager, Resident Assessment Instrument (RAI) Coordinator, Infection Prevention and Control Coordinator, Staff Development Coordingator, Nursing staff (Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW)), dietary staff, including the Cooks and Dietary Aides, Laundry, Housekeeping, and Maintenance staff

During the review, the inspectors: toured the home; reviewed clinical health records for identified residents; reviewed relevant policies and procedures, meeting minutes and documents; and observed food production systems, meal service, resident care, laundry, housekeeping, and maintenance processes

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

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Skin and Wound Care

Snack Observation

Sufficient Staffing

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

24 WN(s)
16 VPC(s)
7 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 73. (1)	CO #004	2014_278539_0013	107
O.Reg 79/10 s. 8. (1)	CO #005	2014_278539_0013	107

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. 6. Plan of care
Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

A) On January 20, 2015, resident #008 was observed to have long facial hair on their chin. Interview with PSWs indicated that the resident’s facial hair was sometimes shaved when it got long. The resident stated they often had to remind staff to shave the resident. The resident’s written plan of care and Kardex were reviewed and did not give any direction to staff in relation to shaving. The flow sheets indicated that the resident was not shaved during the entire month of January 2015. The plan of care did not provide clear direction to staff in relation to shaving. (561)

B) During the observation of the medication pass on January 28, 2015, resident #011 was given medications at lunch time that were crushed and given with apple sauce. The registered staff was interviewed and indicated that the resident was at high risk for choking and required crushed medications given with apple sauce. The resident's written plan of care was reviewed and indicated that the resident was high risk for choking but did not include the direction for crushing the resident's medications. The electronic medication administration record(EMAR) did not indicate that the resident's medications needed to be crushed and given with apple sauce. The resident's plan of care did not set out clear direction to staff who administer medications. (561)

C) An identified resident #040 had facial hairs of approximately one centimeter on the side of their mouth and on their chin. The resident's care plan, the document used by

staff and others who provided direct care to the resident, was reviewed and it did not contain any information related to their facial hair. The personal support worker (PSW) providing care to the resident was interviewed and they confirmed the presence of the resident's facial hair and reported that the resident's facial hair was not removed as that was the preference of the resident's Power of Attorney (POA). The PSW confirmed that there was no information related to the resident's facial hair included in the care plan used by staff who provided direct care to the resident. The registered staff was interviewed and they confirmed the presence of the resident's facial hair and that it was the home's expectations that long facial hair was removed from residents. They also reported that the resident's facial hair was not removed as it was the preference of the resident's POA. They also confirmed that the information was not included in the resident's plan of care used by staff who provide direct care to the resident. (123) [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to residents as specified in the plan in relation to call bells.

A) Resident #041 was observed during stage one of the Resident Quality Inspection. On January 19, 2015, the resident was observed in bed and the call bell was not within the resident's reach. It was observed on the floor beside resident’s bed. The resident’s written plan of care indicated that the call bell shall be within reach at all times.

B) Resident #042 was observed on January 20, 2015 in bed and the resident’s call bell was hanging behind the headboard. The resident’s written plan of care indicated that the resident required a call bell within reach at all times.

The home did not ensure that the call bell was within reach at all times for residents #041 and #042 as specified in their plans of care. (561) [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care for residents was provided to the residents as specified in the plan in relation to diet order.

A) The plan of care for resident #020 required thickened fluids at all meals and snacks.
i) At the lunch meal January 26, 2015, the resident was provided two glasses of thickened fluids and one glass of thin fluids. The PSW that served the food stated the resident disliked the thickened fluids so they gave the resident the thin fluids. The

Registered Nurse (RN) confirmed that the resident's request for thin fluids was not communicated to her and confirmed the resident was not to receive thin fluids due to a problem with dysphagia.
ii) The resident had a plan of care that required a nutritional supplement. The resident required thickened fluids and registered staff and PSW staff interviewed stated that all thickened supplements were prepared in the kitchen, labeled, and sent up with the snack cart. At the afternoon snack pass January 30, 2015, the supplement was not available on the snack cart. Dietary staff and the Nutrition Manager confirmed a label for the supplement was not in the dietary computer system and the item was not prepared or provided for the resident on January 28 and 30, 2015. Dietary staff stated they were not aware the resident required a supplement for the snack pass and confirmed the supplement was not prepared. The supplement was ordered more than two months prior. PSW flow sheets for snack consumption indicated the resident was to receive a special snack and nutritional supplement at the snack pass; however, the documentation was unclear as to whether the resident was taking both the supplement and the special snack and some of the documentation was incomplete/blank in relation to the special snacks. At the recent nutritional review, documentation indicated the resident's weight had decreased the past quarter.

B) At the lunch meal January 26, 2015, the pureed soup served to residents was served at a nectar consistency. Residents requiring honey consistency or pudding consistency thickened fluids were provided the soup. Dietary staff confirmed that all residents in the dining room received the same thickened pureed soup. According to the "diet spreadsheet" (contains diet order information), several residents required honey thickened fluids or pudding thickened fluids.

C) At the lunch meal January 26, 2015, not all the thickened consistency fluids at the tables were of the same thickness for the same resident. Example: milk was honey thick, water was nectar thick and another milk was thicker than honey thick. (107)

D) Resident #019's plan of care required thickened fluids. At the afternoon snack service January 27, 2015 the resident was provided with a beverage that was not at the ordered consistency(did not appear to have thickener added). Staff serving the snacks confirmed the nutritional supplement was not the required consistency.

E) Resident #040's plan of care required thickened fluids. At the morning snack pass February 5, 2015, a labeled supplement was not prepared to the correct consistency. Staff confirmed the labeled supplement was not the consistency identified on the label. The resident required the fluid consistency identified on the label. (107) [s. 6.

(7)]

Additional Required Actions:

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

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 with ensuring that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident (s. 6(1)(c)), to be implemented voluntarily.

WN #2: 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:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

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:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

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:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the meal and snack times were reviewed with the Residents' Council. This was confirmed by the Dietary Manager on January 28, 2015. [s. 73. (1) 2.]

2. The licensee has failed to ensure that residents were monitored during meals.

A) The Home's policy "Pleasurable Dining Service - FNSMS010" stated the RN/RPN must supervise and assist in the dining areas.

B) Staff were not in the third floor dining room when the inspector entered the dining room on January 26, 2015, at 1340 hours. Three residents had food and fluids in-front of them. The Registered staff were not in the dining room.

C) The dining room on the first floor was left unattended by staff on January 27, 2015 at the breakfast meal. Staff stated that the Social Worker was to keep an eye on the dining room (their office was off the side of the dining area); however, the Social Worker did not have a visual sight line to the dining area and staff were not in the dining area (as per the Home's policy).

D) The dining room on the first floor was left unattended by staff on February 4, 2015 between 1325 hours to 1335 hours. Three residents were still eating with food and fluids in-front of them. Two of the residents left while the staff were away from the dining room; however, one resident remained at the table and continued to consume food and fluids. The resident attempted to get up from their chair; however, they were unable to do so. PSW staff returned to the dining area and it was observed that the resident was unable to safely transfer independently from their dining chair. Staff were not in the dining area, the Social Worker was not in their office (off the dining room) and staff were not available in the front Admission Coordinator's office. Residents were not monitored while eating and drinking during that time. [s. 73. (1) 4.]

3. The licensee has failed to ensure that a process was in place to ensure that food service workers and other staff assisting residents were aware of the residents' diets, special needs and preferences.

A) At the lunch meal January 27, 2015, resident #033 was served a meal in the dining room. The resident usually ate in a different location in the home. The diet list (used to provide direction about diet type and texture, special preferences, etc.) did not include the resident's name or information and the resident was provided with a regular textured meal (roast beef sandwich and spinach salad). The resident required a pureed texture (as per the RN who located the resident's diet order on the computer). The error was not discovered until the inspector asked for clarification and action was not taken by the staff for an extended period of time while they were checking the resident's diet texture at the nursing station.

B) Resident #020 required a nutritional supplement. This information was included on the resident's plan of care; however, direction was not provided to staff preparing the supplements in the kitchen. The resident required thickened fluids and staff stated the thickened supplements were prepared in the kitchen and labeled for the individual resident. The Nutrition Manager and the Dietary Aide preparing the supplements confirmed that a sticker (with the resident's name and required supplement) was not included in the printed labels and no direction was in place for staff preparing the supplements to identify that this resident required the supplement. The resident was not receiving the supplement according to staff serving the afternoon snacks January 30, 2015 and the inspector confirmed the supplement was not on the snack cart January 28, 30, 2015. The supplement was ordered more than two months prior. [s. 73. (1) 5.]

Additional Required Actions:

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

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 with a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences (r. 73(1)5), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all menu items were prepared according to the planned menu at the lunch meal January 19, 2015.

A) The posted menu stated shaved pork on a bun with a corn cobbette and mandarin oranges for dessert or mushroom and Swiss cheese quiche, hash browned potatoes, marinated zucchini, and broken glass jellies.

B) Residents receiving a pureed texture menu were provided pureed squash and parsnips instead of the corn cobbette; pureed cold mixed vegetables with no marinade instead of the marinated zucchini; instant mashed potatoes instead of seasoned hash browned potatoes; pureed fruit cocktail instead of the mandarin oranges; and pureed pineapple instead of the broken glass jellies. The Cook and Nutrition Manager stated that the home usually used a purchased pureed corn product; however, the purchased corn was not ordered and they had extra squash/parsnip so that was substituted for the minced and pureed textured menus. The Cook stated they did not have enough zucchini for the pureed texture marinated zucchini so mixed vegetables with no marinade was substituted. The Nutrition Manager stated they were not made aware that there were insufficient quantities of zucchini and was unaware that a substitution had been made. The item that was supposed to be pureed mushroom Swiss quiche, that was served to residents for the first half of the meal on the second floor, was different than the pureed product sent up at the end of the meal. The first product was thick and tasted like macaroni with no mushroom flavour and the second product tasted like cream of mushroom soup. The two items were different consistencies and different colours. The Cook was unable to state why the products appeared and tasted different and stated that sometimes the home used left overs for the pureed texture menu and it might have been a different type of quiche.

C) Residents receiving a minced texture menu were provided squash and parsnips instead of the corn cobette; and had mixed vegetables added to their marinated zucchini.

D) The recipe for the broken glass dessert required whipped topping to be added to strawberry jello. The dessert served to residents included only red and green jello.

E) Menu items were not prepared according to the planned menu.

The licensee failed to ensure all menu items were prepared according to the planned

menu at the lunch meal January 28, 2015.

A) The menu required a sliced meat plate that contained sliced roast beef and sliced turkey. The minced textured meat plate was prepared with a combination of sliced deli turkey meat and diced cooked chicken (different textures and colours). The Cook was unable to state why they used two different meats except stating that the chicken was prepared the day prior so it was used. The meat plate was to be served with a dinner roll; however, insufficient quantities were available so sliced bread was substituted at the last minute.

B) The recipe for the hot dog included cheese; however, a cheese slice was not included on the hot dogs served to residents.

C) The menu identified tropical chiffon for dessert. Dietary staff confirmed banana pudding was served (was again served on the afternoon snack cart and at the following dinner meal).

D) The menu required pears as an alternate dessert choice for the renal menu. Staff confirmed the pears were not prepared or available for service. One resident in the identified dining area required a renal menu.

E) The menu required a 1/2 serving of a banana. A whole banana was served to residents and staff stated there were insufficient quantities to prepare the bananas for the minced and pureed texture. Tropical fruit was substituted for the minced and pureed menus which was not consistent with the planned menu.

The licensee failed to ensure that all menu items were prepared according to the planned menu at the dinner meal January 28, 2015.

A) The planned menu required cauliflower; however, lima beans were served as a substitution. [s. 72. (2) (d)]

2. The licensee has failed to ensure that all menu substitutions were communicated to residents receiving a texture modified menu at the lunch meal January 19, 2015.

A) The posted menu stated shaved pork on a bun with a corn cobette and mandarin oranges for dessert or mushroom and Swiss cheese quiche, marinated zucchini, and broken glass jellies.

B) Residents receiving a pureed texture menu were provided pureed squash and parsnips instead of the corn cobette/creamed corn; pureed cold mixed vegetables with no marinade instead of the marinated zucchini; pureed fruit cocktail instead of the mandarin oranges; and applesauce instead of the broken glass jellies. Staff serving the desserts stated it was all pureed mandarin oranges and were not actually aware of what they were serving to residents. Staff serving and portioning also were unclear what the squash/parsnip mix was and what the orange vegetable was (pureed mixed vegetables). The substitutions were not communicated to staff serving nor to residents who were eating the items. The Nutrition Manager stated they were not made aware that some of the substitutions had been made. The item that was supposed to be mushroom Swiss quiche, that was served to residents for the first half of the meal was different than the pureed product sent up at the end of the meal. The first product was thick and tasted like macaroni with no mushroom flavour and the second product tasted like cream of mushroom soup. The two items were different consistencies and different colours. The Cook was unable to state why the products appeared and tasted different and stated that sometimes the home used left overs first for the pureed and it might have been a different type of quiche.

C) Residents receiving a minced texture menu were provided squash and parsnips instead of the corn cobette and had mixed vegetables added to their marinated zucchini.

D) The menu served to residents was not consistent with the planned menu and the substitutions were not communicated to staff and residents. [s. 72. (2) (f)]

3. The licensee has failed to ensure that all food and fluids were prepared and served using methods that preserved taste, nutritive value, appearance and food quality.

A) At the lunch meal January 19, 2015, residents receiving a pureed menu received cold pureed mixed vegetables with their meal instead of the pureed marinated zucchini. The mixed vegetables served did not contain seasoning or sauce and the flavour and quality of the vegetables was not maintained by serving them cold. The nutritive value, taste, and quality of the pureed pork was reduced in comparison to the regular and minced texture pork. The regular texture and minced texture pork was flavourful and contained recognizable gravy added to the product; however, the pureed pork did not have any flavour and tasted like pork with water added only. The Cook stated that gravy was added to the pureed pork; however, the taste of the pureed texture pork was considerably less flavourful than the regular and minced

textured pork.

B) At the lunch meal February 5, 2015, sherbet was served for dessert. The sherbet had previously melted in the nappies and was then re-frozen and served to residents. The appearance of the sherbet was not maintained (altered colour and consistency).

C) Skim milk was served with coffee and tea on the snack cart which did not preserve the taste of the beverage. Cream and 2% milk were not available. Dietary staff in the kitchen stated the coffee was not to be served with skim milk.

D) The recipe for fish cakes required tartar sauce for the regular texture, cream sauce for the minced texture and a brown gravy for the pureed texture. The same quality and taste were not maintained for the pureed texture fish cakes.

E) The recipe for pureed soup did not contain a thickener. The pureed soup provided to residents contained thickener for all residents. The taste and palatability of the soup was changed with the addition of thickener for those that did not require thickened soup. [s. 72. (3) (a)]

4. The licensee has failed to ensure that all food was stored using methods that prevented adulteration and contamination. Items in the dry storage area of the kitchen (cookies, crackers and dry ingredients) were stored in opened packages or boxes that were not sealed to prevent contamination/infestation and to keep the items fresh. Dietary staff confirmed that all packages were to be sealed or foods were to be transferred to a sealed container/bag after opening if the package could no longer be sealed. The home's Pest Management records for January 9, 2015, identified the traps were moved for activity near the peanut butter trays. [s. 72. (3) (b)]

Additional Required Actions:

CO # - 003, 004, 006, 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #047 was protected from abuse.

Resident #047 was seen crying. The resident told a PSW that they had been physically abused by a PSW. Review of the home's investigation notes identified that the Registered Nurse asked the resident if they knew who had hit them. The resident then pointed at a Personal Support Worker (PSW) who had entered the room. The staff was terminated following the home's investigation. On February 3, 2015, when resident #047 was questioned by the inspector, they were unable to recall the event; however, according to the home's investigations notes, resident #047 had been able to recall the details on a number of occasions, following the incident.

The Administrator confirmed that the same PSW had been involved in the incident with resident #047 as well as an incident where staff received a three day suspension in regards to neglect.

The home has indeed investigated, disciplined, and terminated the PSW involved; however, the home had not mitigated the risk as the staff's behavior had not changed. The home's training records identified that the PSW involved had not received annual abuse training in 2010, 2011 or 2012, nor did they have a police check on file. Despite the homes efforts, residents continued to be exposed to possible or potential abuse and neglect. [s. 19. (1)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A1)The following order(s) have been amended:CO# 005

WN #5: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were treated with courtesy and respect in a way that fully respected their dignity.

A) At the lunch meal January 28, 2015, resident #051's plate was removed and the resident was not provided another plate. The resident was observed eating their hot dog without a plate and the resident had to place their hot dog on the table between bites.

B) Residents had peeled bananas for dessert at the lunch meal January 28, 2015; however, a plate was not provided for the bananas. Residents had to place them on a dirty napkin on the table.

C) Resident #052 was being assisted with a beverage at the snack pass January 27, 2015. The beverage was spilling onto the resident's sweater and staff did not provide protection for the resident's clothing. The resident's clothing was noted to be wet after the snack pass. [s. 3. (1) 1.]

2. The licensee has failed to ensure that each resident had 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 January 28, 2015, during an observation of the medication pass, it was noted that discarded medication pouches that identified residents by name, and their prescribed medications, were being disposed of in the regular garbage. The Charge Nurse on the unit confirmed that the empty medication pouches should have been discarded in the container on the medication cart designated for proper disposal to protect resident’s personal health information. [s. 3. (1) 11.]

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 with ensuring the rights of residents are fully respected and promoted, including 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, 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 (s. 3(1)11.iv), to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The Policy, "Medication Pass - Procedure, Index Number: 04-02-20", reviewed June 23, 2014, indicated that "the nurse or staff who prepares a medication for administration, or prepares an injection must administer it". Two registered staff confirmed that sometimes the family member of resident #015 gave the medications to the resident. The charge nurse was interviewed and indicated that sometimes the resident took a long time to take medications and nurses did not have time to wait until the resident took them. The family member would then give the medications to the resident. The home did not follow their policy related to medication administration. [s. 8. (1) (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 with ensuring that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment as evidenced by:

The bed of resident #040 was reviewed. The resident was unable to reposition themselves in bed independently; required two bed side rails at all times while in bed; was unable to safely lower the bed rails; and used an air mattress. Air mattresses fail assessments of zones of entrapment due to the compressibility of air mattresses. The air mattress on the bed of resident #040 was observed to freely slide from side to side creating potential entrapment risks in zone three between the air mattress and the bed side rails. There were no interventions such as a bed rail pad or bolster implemented to reduce the resident's risk of entrapment.

The home's Environmental Manager (EM) assessed the bed side rails of resident #040 for entrapment risk and confirmed that resident #040's bed side rails failed the assessment for the risk of entrapment between the bedside rails and the mattress. They reported that the resident's air mattress was not tightened underneath the bed with the belts to prevent the side to side movement of the mattress which created the risk of entrapment of resident between the bed side rails and the air mattress.

The home failed to take steps to prevent the entrapment of resident #040 when bed rails and an air mattress were used on their bed. [s. 15. (1) (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 with ensuring that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #8: 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 failed to ensure that the home was equipped with a resident-staff communication and response system that was easily accessed and used by residents, staff and visitors at all times,

A) On January 19, 2015 at 1220 hours during stage one of the Resident Quality Inspection the call bell in the bathroom of room 301 was pulled and the red string became detached from the call system on the wall and did not activate the call system. The registered staff was made aware and reported that maintenance would be notified. On January 20, and 23, 2015 the bathroom was checked and the cord was still not fixed. On January 23, 2015, the Environmental Manager confirmed that the maintenance request was never submitted for the call bell in room 301. The home failed to ensure that the resident-staff communication and response system was functioning at all times. (561)

B) The call bell in the first floor washroom could not be used by residents, staff or family. There was a large knot on the end of the pull cord which prevented the system from being activated. Environmental Services confirmed the bell could not be activated. (107) [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 with ensuring that the home is equipped with a resident-staff communication and response system that is easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with as evidenced by:
A) The home's policy and procedures, "Abuse or Neglect Policy #RCS P-10", revised date January 10, 2014, was reviewed. It included: "All allegations of abuse and neglect will be promptly reported, investigated and based on the outcome of the investigation progressive discipline may take place up to and including termination." "On becoming aware of abuse or neglect, the first person having knowledge of this shall immediately inform the MOHLTC and the Director of Nursing or delegate and if not available, the Administrator." "The Administrator or DON must notify the Ministry of Health, Long-Term Care Branch and the Vice-President of Operations. Section 24(1) of the LTCHA requires that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that

resulted in harm or risk of harm to the resident shall immediately report the suspicion and the information on which it is based to the Director." "The supervisor or the person discovering the abuse should prepare a written report (Suspected Abuse/Neglect Report) containing at a minimum the following information: What occurred? When it occurred? Who was involved, including witnesses? Where it occurred and the names of those in the vicinity who may be witnesses. Written statements from witnesses and residents (tape recorder may be used if unable to write). Any other significant information pertaining to the incident."

B) Resident #016 reported to the inspector that they were treated roughly by an identified staff member in the home. The Clinical Director of Nursing (CDON) was interviewed and reported that they became aware of the alleged physical abuse of resident #016 by an identified staff member while they were conducting an alleged abuse investigation related to another resident and involving the same identified staff member. They reported that the home took action with the staff as per the home's policies and procedures. The CDON confirmed that they did not notify the Director of the alleged abuse of resident #016 as per the home's policies and procedures.

C) The home was requested to produce the home's internal investigation records related to the the alleged physical abuse of resident #016 by the staff member. The home did not produce the information. The CDON confirmed that the home did not have investigation records of the alleged physical abuse of resident #016 as an investigation (as per the home's policies and procedures) did not take place. The staff member was already off work pending the outcome of the investigation of a separate alleged abuse incident and they did not return to the home.
The home did not conduct and document an investigation related to the alleged abuse of resident #016 as per the policies and procedures. [s. 20. (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 with ensuring there is a written policy to promote zero tolerance of abuse and neglect of residents and that the policy is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Nursing and Personal Support Services program included relevant policies and procedures and protocols related to hypoglycemia management and that the policies were available to staff providing care to residents.

A policy related to hypoglycemia management was provided to the inspector by the home; however, a policy number and date for the protocol was not included on the forms provided. Three registered staff members were asked for the hypoglycemia management policy on January 30, 2015, and the staff members were unable to locate the policy. The three staff searched for over 15 minutes and were unable to locate a policy on the home's computers or in the books available at the nursing station on the third floor. Staff were unable to locate the home's policy. The Director of Nursing confirmed the policy that was provided to the inspector had not been implemented at the home. Staff providing care to resident #020 did not follow a consistent method for the treatment and management of hypoglycemia on numerous occasions between September 2014 and January 2015. [s. 30. (1) 1.]

2. The licensee has failed to ensure that the restorative care program was evaluated and updated annually. This was confirmed by the Staff Co-ordinator. [s. 30. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that for the Nursing and Personal Support Services program, there are relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) Resident #008 returned from hospital with a staged pressure ulcer. The resident's health records were reviewed and indicated that the staff did not use a specific tool designed for skin and wound assessment when the resident's wound was assessed post re-admission from the hospital. The Skin Care and Wound Coordinator was interviewed and confirmed that the staff used a general skin/wound note to document the assessment and it did not have a full assessment of the resident's wound. [s. 50. (2) (b) (i)]

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 with ensuring that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment (r. 50(2)(b)(i)), to be implemented voluntarily.

WN #12: 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 there was a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration. Food and fluid intake records for January 2015 were reviewed.

A) Food and fluid intake records were often incomplete, resulting in the inability to evaluate the resident's intake and risks related to nutrition and hydration. Some

examples:

i) Resident #061 required special snacks and items with meals. Documentation for some of the items was blank for the entire month of January 2015 with the exception of one record that was an error. It was unclear if the resident was taking the item, if it was available and offered, or if it was being refused. The intake of the item could not be evaluated and was not being monitored by staff. The resident was at nutritional risk. Documentation was also incomplete for seven days (blank) where there was no record if the resident was offered or consumed one of the other required items. The resident also required a certain level of fluids; however, staff were not always totaling the fluids consumed at the end of the day (as per the home's policy), preventing easy identification of concerns.

ii) Resident #062 required special items at meals and snacks. Documentation was blank related to the offering or consumption of the special snacks and the items were not monitored by staff. Documentation at the afternoon nourishment also had a slash under "food". It was unclear if the resident was offered a snack at the afternoon snack pass or if they refused. The resident was at nutritional risk.

iii) Resident #040 required special items at the breakfast meal. Information on the food and fluid intake records identified the resident also required an additional item; however, this was not included on the kitchen diet spreadsheet provided to the inspector. The documents were not consistent. All of the above listed items were together on the food and fluid intake records and it was not clear from the documentation if the resident was consuming any of these. Not all items were being monitored and it was unclear which, if any of the items were being consumed based on the documentation on the flow sheets. The resident's intake of these items could not be evaluated.
The consumption of afternoon and evening snacks was not consistently monitored by staff. Intake records were blank for afternoon snacks (all month - January) and evening snacks (January 1 to 16). It was unclear if the resident was being offered a snack in addition to the special beverage ordered. The resident was at nutritional risk.

iv) Resident #015 required a nutritional supplement between meals at the snack pass. The supplement was identified on the food and fluid intake record; however, documentation was incomplete (missing 19/31 mornings; 5/31 afternoons; 23/31 evenings). The food and fluid intake record also identified the resident required special items at breakfast. This was not identified on the diet spreadsheet from the

kitchen. All the items were grouped together on the intake record and it was unclear from the documentation which items were consumed/not consumed/offered. The resident's intake of these items was not monitored and could not be evaluated. Fluid intake was not consistently totaled by evening staff (as per the home's policy) (21/31 days), resulting in the inability to quickly flag poor intake. On the days that the home did total the resident's fluid intake, the resident was below their fluid target for the day. The resident was at nutritional risk.

B) Food and fluid intake records were not completed according to the legend codes provided on the form, resulting in the inability to evaluate the intake. For example, a slash was documented under food at snacks for numerous residents. It was unclear if the residents were offered a snack or if they refused the snack or what the slash meant.

C) Nineteen resident's food and fluid intake records were reviewed with the same concerns identified related to incomplete documentation and documentation not matching the identified legend/codes.

D) Staff confirmed the documentation was incomplete, and/or difficult to evaluate. [s. 68. (2) (d)]

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 with ensuring there is a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (2) The licensee shall ensure that each menu,
(b) provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time. O. Reg. 79/10, s. 71 (2).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a variety of foods were served to residents. The inspector was at the home over a two week period, and multiple foods were repeated during that two weeks. Residents identified concerns with menu variety through their complaint management process.

A) Peanut butter was offered daily at the breakfast menu and peanut butter and jam sandwiches were offered at the lunch meal Monday lunch and for the vegetarian menu Tuesday lunch (next day) and on the snack menu Week 1 Wednesday, Week 2 Wednesday, Friday Week 3. Residents voiced concerns with peanut butter sandwiches on the menu through the Client Service Response forms (complaint process).

B) Roast beef sandwich was served Week 4 Tuesday lunch, Wednesday lunch, Thursday lunch (renal menu) and Thursday evening snack. Roast beef sandwich was also served Week 1 Thursday lunch (February 5, 2015) and Saturday evening snack.

C) Both choices offered for the lunch meal February 5, 2015 contained spinach (roast beef sandwich with spinach salad or spinach omelet).

D) Hamburger was served for the renal menu Week 4 Wednesday supper, Friday lunch, Saturday lunch, Sunday supper seasoned beef (similar).

E) Lemon flavoured desserts were planned for Week 3 Monday, Friday lunch, Week 4 Wednesday supper, Friday lunch (renal).

F) Banana pudding was served January 28, 2015, at the lunch meal, afternoon snack and supper meal, and again February 5 lunch for residents requiring thickened fluids.

G) Canned peaches/pears/fruit cocktail - served Week 3 Monday lunch, Tuesday lunch, Saturday supper, Week 4 Monday lunch (dessert and side), Wednesday lunch (renal), Thursday breakfast, Friday supper, Saturday lunch.

H) Pineapple served Week 3 Monday lunch, Tuesday supper, Friday lunch, Week 4 Thursday breakfast and Thursday lunch

I) Both entrees had cabbage on Monday Week 4 - cabbage rolls and coleslaw.

J) Cheese sandwich served Week 4 lunch Thursday and Saturday (vegetarian, pureed texture) and evening snack Saturday.

K) Cauliflower served Friday Week 3 lunch, Week 4 lunch Monday and Wednesday.

L) Veggie dog for the vegetarian menu Week 4 Wednesday lunch and Thursday supper. [s. 71. (2) (b)]

2. The licensee has failed to ensure that all residents were offered a snack in the afternoon and evening.

A) During stage one of the Resident Quality Inspection, residents stated they were not routinely offered a snack in the afternoon and evening or they had to ask to receive a snack.

B) At the afternoon snack pass January 27, 2015, not all residents were offered a snack in addition to a beverage.
Residents #053, #054, #008, #055, #052, #056 were offered a beverage; however, were not offered a snack.
The container of pureed cookies was not opened or provided to any resident and was not offered during the observed snack pass.

C) At the afternoon snack pass on January 28, 2015, not all residents were offered a snack in addition to a beverage. Only part of the snack pass was observed; however, 3/5 residents were not offered a snack, in addition to a beverage (residents #057, #058, and #059). Resident #060 was only offered the prescribed snack (received this daily) and was not offered the planned snack from the snack cart.

D) Food and fluid intake records for numerous residents reflected snacks were not routinely offered during the afternoon and evening snack pass. Documentation did not reflect the residents refused; the documents were either blank or had a slash that indicated a snack was not provided to the resident.

i) Resident #012 had stated they were not consistently offered a snack in the afternoon and evening. Flow sheets for January 2015 reflected food was provided in the afternoon on 6/28 days and one refusal for the evening snack. Documentation was blank (incomplete) for the afternoon snack pass on 16/28 days in January and 5/28 days recorded as not provided.
Documentation at the evening snack pass was incomplete on 5/28 days and a food snack was not provided on 21/28 days.

ii) Resident #040 stated they had to ask for a snack and was not routinely offered a snack in the afternoon or evening. Documentation on the flow sheets for January 2015 reflected food was offered on 3/28 days and only a beverage was provided on 25/28 days in the afternoon, and food was not provided in the evening between January 1-16, 2015.

iii) Resident #008 stated they were not routinely offered a snack in addition to a beverage in the afternoon and evening. Documentation on the flow sheets for January 2015 reflected a snack was provided to the resident on only one afternoon in January 2015. During the observed afternoon snack pass on January 27, 2015 the resident was offered a beverage; however, was not offered a snack. [s. 71. (3) (c)]

3. The licensee has failed to ensure that all planned menu items were available and offered at each meal and snack on January 27, 28, 2015.

A) The planned menu for Week 4 Tuesday (January 27) required kiwi drink; however, this was not available on the snack cart. The pureed snack was available; however, was not offered to residents.

B) The planned menu for Week 4 Wednesday (January 28) required a raspberry drink; however, this was not available on the snack cart on the 2nd floor. The pureed snack (pureed oreos) was available on the snack cart; however, was not offered to residents. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that each menu provides a variety of foods (r. 71(2)(b)), that each resident is offered a minimum of a snack in the afternoon and evening (r. 71(3)(c)) and that the planned menu items are offered and available at each meal and snack (r. 71(4)), to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff receive retraining annually related to abuse. A review was completed of the employee's file who was involved in an incident with resident #047 and another incident with a different resident. The employee's file indicated they were hired in 2009. No record was located for abuse retraining for 2010, 2011 or 2012. This was confirmed by the Administrator on February 5, 2015. [s. 76. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the persons who have received training under subsection (2) receive training in the areas mentioned in that subsection at times or at intervals provided for in the regulations, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that they seek the advice of the Residents' Council in developing and carrying out the satisfaction survey and in acting on its results.

The home completed satisfaction surveys through the Abaqis program. The Vice President of Resident Council was unable to confirm if the Residents' Council was able to provide advice in developing and carrying out the satisfaction survey. Review of the 2014 Residents' Council meeting minutes confirmed that the advice of the Council was not sought regarding the satisfaction survey specifically related to its development, implementation and in acting on its results. This was confirmed by the Social Worker on February 5, 2015. [s. 85. (3)]

2. The licensee has failed to ensure that the results of the satisfaction survey were made available to the Residents' Council in order to seek the advice of the Council about the survey.

Review of the 2014 Residents' Council meeting minutes confirmed that the results of the satisfaction survey were not documented and made available to the Council in order to seek their advice regarding the survey. The Social Worker confirmed on February 5, 2015, that the negative results of the Abaqis surveys were dealt with through their complaints program; however, the home did not share these results due to protection of privacy. [s. 85. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring 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 (s. 85(3)) and ensuring that 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) (s. 85(4)(a)), to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

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

A) The washroom on the first floor had an odour and the walls had the same residue (looked like feces) between January 19 - February 5, 2015. The Environmental Manager stated that the walls were to be cleaned when the floors were cleaned (2-3 times daily). The walls had not been cleaned during that time and the same residue was observed on the walls.

B) During stage one of this inspection, resident #016 identified concerns about cleanliness of their room. On January 30, 2015 at 1650 hours a dried on brown substance was noticed to be smeared on the wall by the toilet paper holder. The bathroom smelled like feces. On February 5, 2015 at 1625 hours most of the same brown substance was still noted on the wall by the toilet paper holder. The seal (caulking) around the toilet base was also noted to be cracking and in poor repair.

C) The flooring around corners and around doorways appeared dirty. There was a build up of soiling in those areas throughout this inspection.

D) On January 26, 2015, in the first floor dining room the fronts of the servery area cupboards and along the bottom where the cupboards met the floor were noted to be dirty with food stains, dirt, and grime and appeared unclean.

E) Dried on food splatters were observed on the wall outside the dining area on the second floor January 26, 2015 and the splatters remained visible on January 30, 2015.

F) During the initial home tour on January 19, 2015, it was observed that the floor in the spa room on the third floor was dirty and small amounts of feces were observed on the floor of one of the shower rooms. There was also an offensive odour present in the spa room. The spa room was observed on the following day and the floor was dirty with small amounts of hair on the floor in one of the shower rooms. (561)

G) The Environmental Manager stated that they had been reduced in staff and were behind on the day to day activities. [s. 87. (2) (a)]

2. The licensee failed to ensure that procedures were 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: (ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

A) Resident #034 stated their wheelchair had not been cleaned for five months and stated that it had a foul odour. The wheelchair had a noticable odour on February 4, 2015, when observed by the inspector.

B) The home's policy "RCS E-80 Cleaning of medical/personal care equipment and contact surfaces" required weekly cleaning and disinfection of wheelchairs, walkers and canes. Registered staff stated that the wheelchairs were to be cleaned weekly on bath days and stated staff were to sign off that the wheelchairs were cleaned on the "Daily Wheelchair Cleaning Schedule" form at the nursing station. The Registered Nurse and Nurse Manager confirmed that the cleaning sign off list for the month of January, 2015, did not contain the resident's name and staff confirmed that the documentation reflected only six wheelchairs were signed as cleaned for the month of

January 2015.

C) Registered staff confirmed the wheelchair cleaning sign off form did not have all of the resident's names on the sheet who required wheelchair cleaning (names were crossed off; however, the new residents' names were not replaced) and there was no evidence that more than six wheelchairs were cleaned (once) for the month of January, 2015. [s. 87. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that procedures are developed and implemented for, (a) cleaning of the home, including, (i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and (ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces (r. 87(2)(a)) and that procedures are 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: (ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids (r. 87(2)(b)), to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint.
Several concerns were voiced by residents/families (identified on the Home's complaint management system - Client Service Response Forms) that there was no evidence that the concerns were investigated or responded to.

A) A concern was voiced about the taste of the food in October 2014 (no actual date on the concern form). A response was provided to the resident for other concerns identified in the complaint; however, there was no evidence the food concerns were investigated or responded to.

B) A concern was voiced about food temperatures on December 8, 2014; however, there was no evidence this was investigated or responded to.

C) A concern was voiced about the taste of food on December 8, 2014 from a different resident; however, there was no evidence the concern was investigated.

D) Concerns were voiced related to menu variety, cold food, and meal choice in October 2014 (no specific date provided). There was no evidence these concerns were investigated or responded to.

E) Concerns were voiced related to meal service on January 19, 2015; however, there was no evidence that the concerns were investigated or responded to.

F) Concerns were voiced about a resident's hydration in January, 2015. The response provided to the family did not include a review of the resident's actual hydration (as noted in their food and fluid intake records), did not include a referral to the Registered Dietitian for review of the concern or follow up/investigation of what the resident was consuming at meals/snacks and the resident's level of assistance required versus what was provided. The concerns related to hydration were not thoroughly investigated. [s. 101. (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 with ensuring that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)

Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.

2. The signature of the person placing the order.

3. The name, strength and quantity of the drug.

4. The name of the place from which the drug is ordered.

5. The name of the resident for whom the drug is prescribed, where applicable.

6. The prescription number, where applicable.

7. The date the drug is received in the home.

8. The signature of the person acknowledging receipt of the drug on behalf of the home.

9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug record had the following information recorded in respect of every drug that was ordered and received in the home:
1. The date the drug is ordered
2. The signature of the person placing the order
3. The name, strength and quantity of the drug,

The drug order book was reviewed for the months of December 2014 and January 2015 and indicated that not all staff signed for drugs that they reordered, dates were missing of when the drug was reordered, and medications did not have the strength of the medication beside the name of the medication. The Clinical Director of Nursing (CDON) confirmed that when registered staff reorder new medications they must write the date of when the medication was reordered, must provide their signature beside the date and write the name of the medication and the strength of the medication as it is specified on the medication reorder sheet. The CDON confirmed that this was not consistently completed. [s. 133.]

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 with ensuring that a drug record has the following information recorded in respect of every drug that was ordered and received in the home:
1. The date the drug is ordered
2. The signature of the person placing the order
3. The name, strength and quantity of the drug, to be implemented voluntarily.

WN #19: 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 was held to discuss the plan of care and any other matters of importance to the resident and their SDM, within six weeks of the admission of the resident, that the resident and/or their SDM were invited and that a record was kept of the conference.

Resident #018 and their SDM stated they had not been invited and had not attended a six week conference to discuss the resident's care. Documentation did not reflect that a six week care conference was completed. The Social Worker, who was responsible for scheduling the six week conference, stated the six week care conference was scheduled then later canceled due to an outbreak at the home. The Social Worker confirmed that there was no evidence the meeting was re-scheduled for after the outbreak and no evidence that the six week care conference occurred. [s. 27. (1)]

WN #20: 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. (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 ensure that each resident of the home received preventive and basic foot care services including the cutting of toenails, to ensure comfort.

Resident #047’s plan of care, which the home referred to as the care plan, identified that resident #047 was to receive foot care by the foot care nurse, every four to six weeks. On review of resident #047’s progress notes it was identified that nail care had not been documented as being done every four to six weeks in 2014. The last foot care done in 2014 for resident #047 indicated 11 weeks since foot care was last done. The Food Care Nurse confirmed the nails had not been cut for 11 weeks and were in need of trimming. The Inspector viewed the resident’s toenails on February 3, 2015, which were in need of trimming. [s. 35. (1)]

2. The licensee has failed to ensure that each resident received fingernail care, including the cutting of fingernails.

On January 20, 2015 resident #008 was observed to have long and jagged fingernails. The resident was further observed between January 21 and January 27, 2015 and their fingernails were long and jagged. The resident stated the staff that provided direct care to the resident did not trim the nails for some time now and the resident would have to remind them. A PSW and registered staff reported that the fingernails were trimmed and cleaned on shower days as per home's policy. The home's policy called Personal Hygiene and Grooming, Index I.D: RCS D-05, revised July 15, 2013, indicated that the "resident's fingernails will be trimmed as part of their shower/bath routine. PSW's to clean nails daily or when required". The PSWs flow sheets were reviewed and indicated that the staff did not trim the fingernails for resident in the entire month of January. [s. 35. (2)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 70. Dietary services
Every licensee of a long-term care home shall ensure that the dietary services component of the nutrition care and dietary services program includes,
(a) menu planning;
(b) food production;
(c) dining and snack service; and
(d) availability of supplies and equipment for food production and dining and snack service. O. Reg. 79/10, s. 70.

Findings/Faits saillants :

1. The licensee failed to ensure that the dietary services component of the nutrition care and dietary services program included, (d) availability of supplies and equipment for food production and dining and snack service.

Some foods were served in disposable dishes at the lunch meals January 23, 26, and 28, 2015. During interview on January 23, 2015, the Nutrition Manager stated that the home did not always have sufficient dishes available if both desserts required a bowl/nappie. Dietary staff stated they ran out of dishes and that was why disposables were being used. On multiple days staff were using disposable dishes for a number of menu items. [s. 70. (d)]

WN #22: The Licensee has failed to comply with LTCHA, 2007, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a criminal reference check was received prior to hiring the staff member involved in the incident with resident #047. A review was completed of a employees file who was hired in 2009. The inspector was unable to locate the police check. The Administrator confirmed that a police check for that employee was not on file. [s. 75. (2)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee’s policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee’s policy to promote zero tolerance of abuse and neglect of residents and what changes and improvements were required to prevent further occurrences.

The home's evaluation [Nursing/Resident Care Annual Evaluation-Resident Abuse and Neglect Policy-reviewed November 8, 2011] completed January 14, 2015, identified that resident, family, and staff interviews were to be completed to determine their awareness of the abuse and neglect policy. This section had not been completed during the evaluation. This was confirmed by the Staff Education Co-Ordinator. [s. 99. (b)]

2. The licensee has failed to ensure that the written record included the names of the persons who participated in the evaluation. The Annual Evaluation completed on January 14, 2015 was completed by one individual. This was confirmed by the Staff Education Co-ordinator. [s. 99. (e)]

WN #24: 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. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the infection prevention and control program evaluation included a written record relating to each evaluation under clause (d) that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The Infection Prevention and Control program had an annual evaluation that identified if the home was in compliance with legislative requirements; however, staff confirmed that an evaluation of the home's actual infection control program was not completed. Information discussed at Infection Prevention and Control meetings and performance measures were not included in the home's evaluation. The evaluation also did not include a summary of any required changes or changes made to the program as a result of the evaluation and only one staff member participated in the program evaluation. [s. 229. (2) (e)]

Issued on this 18 day of June 2015 (A2)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : MICHELLE WARRENER (107) - (A2)

Inspection No. / No de l'inspection : 2015_191107_0001 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-001831-15 (A2)

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

Report Date(s) / Date(s) du Rapport : Jun 18, 2015;(A2)

Licensee / Titulaire de permis : RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

LTC Home / Foyer de SLD : COOKSVILLE CARE CENTRE
55 THE QUEENSWAY WEST, MISSISSAUGA, ON, L5B-1B5

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 : NICOLE FISHER

To RYKKA CARE CENTRES 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 :

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

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures that the care set out in the plan of care, related to access to call bells and the provision of food/fluids according to physician diet order/fluid consistency, is provided to residents as specified in the plan.
The plan shall include, but is not limited to:
1. Education for dietary and nursing staff related to the provision of food and fluids according to the physician orders and process for staff to follow if residents refuse the ordered diet, and the identification and provision of different fluid consistencies.
2. Education for dietary staff related to preparing different consistencies of thickened fluids.
3. Quality management activities related to the provision of fluids and meals according to residents' physician order, accurate preparation and provision of thickened fluids, and the placement of call bells for resident accessibility and according to direction identified in the plan of care.
The plan shall be submitted by April 28, 2015 to Long Term Care Homes Inspector, Michelle Warrener, using e-mail to:
Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. Previously issued May 2014 as a VPC

The licensee has failed to ensure that the care set out in the plan of care for residents was provided to the residents as specified in the plan in relation to diet order.

A) The plan of care for resident #020 required thickened fluids at all meals and snacks.
i) At the lunch meal January 26, 2015, the resident was provided two glasses of thickened fluids and one glass of thin fluids. The PSW that served the food stated the resident disliked the thickened fluids so they gave the resident the thin fluids. The Registered Nurse (RN) confirmed that the resident's request for thin fluids was not communicated to her and confirmed the resident was not to receive thin fluids due to a problem with dysphagia.
ii) The resident had a plan of care that required a nutritional supplement. The resident required thickened fluids and registered staff and PSW staff interviewed stated that all thickened supplements were prepared in the kitchen, labeled, and sent up with the snack cart. At the afternoon snack pass January 30, 2015, the supplement was not available on the snack cart. Dietary staff and the Nutrition Manager confirmed a label for the supplement was not in the dietary computer system and the item was not prepared or provided for the resident on January 28 and 30, 2015. Dietary staff stated they were not aware the resident required a supplement for the snack pass and confirmed the supplement was not prepared. The supplement was ordered more than two months prior. PSW flow sheets for snack consumption indicated the resident was to receive a special snack and nutritional supplement at the snack pass; however, the documentation was unclear as to whether the resident was taking both the supplement and the special snack and some of the documentation was incomplete/blank in relation to the special snacks. At the recent nutritional review, documentation indicated the resident's weight had decreased the past quarter.

B) At the lunch meal January 26, 2015, the pureed soup served to residents was served at a nectar consistency. Residents requiring honey consistency or pudding consistency thickened fluids were provided the soup. Dietary staff confirmed that all residents in the dining room received the same thickened pureed soup. According to

the "diet spreadsheet" (contains diet order information), several residents required honey thickened fluids or pudding thickened fluids.

C) At the lunch meal January 26, 2015, not all the thickened consistency fluids at the tables were of the same thickness for the same resident. Example: milk was honey thick, water was nectar thick and another milk was thicker than honey thick. (107)

D) Resident #019's plan of care required thickened fluids. At the afternoon snack service January 27, 2015 the resident was provided with a beverage that was not at the ordered consistency(did not appear to have thickener added). Staff serving the snacks confirmed the nutritional supplement was not the required consistency.

E) Resident #040's plan of care required thickened fluids. At the morning snack pass February 5, 2015, a labeled supplement was not prepared to the correct consistency. Staff confirmed the labeled supplement was not the consistency identified on the label. The resident required the fluid consistency identified on the label. (107) [s. 6. (7)] (107)

2. The licensee failed to ensure that the care set out in the plan of care was provided to residents as specified in the plan in relation to call bells.

A) Resident #041 was observed during stage one of the Resident Quality Inspection. On January 19, 2015, the resident was observed in bed and the call bell was not within the resident's reach. It was observed on the floor beside resident’s bed. The resident’s written plan of care indicated that the call bell shall be within reach at all times.

B) Resident #042 was observed on January 20, 2015 in bed and the resident’s call bell was hanging behind the headboard. The resident’s written plan of care indicated that the resident required a call bell within reach at all times.

The home did not ensure that the call bell was within reach at all times for residents #041 and #042 as specified in their plans of care. (561) [s. 6. (7)]

(561)

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

Jul 31, 2015

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures that residents are monitored during meals. The plan shall include, but is not limited to:

1. Review of the home's policy around dining room supervision
2. Education for staff related to the process and need for monitoring of residents during meals and dining room supervision when residents are being transported in and out of the dining room
3. Quality management activities related to monitoring residents during meals

The plan shall be submitted by April 28, 2015 to Long Term Care Homes Inspector, Michelle Warrener, via e-mail to: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. Previously issued January 2013 as a VPC

The licensee has failed to ensure that residents were monitored during meals.

A) The Home's policy "Pleasurable Dining Service - FNSMS010" stated the RN/RPN must supervise and assist in the dining areas.

B) Staff were not in the third floor dining room when the inspector entered the dining room on January 26, 2015, at 1340 hours. Three residents had food and fluids in-front of them. The Registered staff were not in the dining room.

C) The dining room on the first floor was left unattended by staff on January 27, 2015 at the breakfast meal. Staff stated that the Social Worker was to keep an eye on the dining room (their office was off the side of the dining area); however, the Social Worker did not have a visual sight line to the dining area and staff were not in the dining area (as per the Home's policy).

D) The dining room on the first floor was left unattended by staff on February 4, 2015 between 1325 hours to 1335 hours. Three residents were still eating with food and fluids in-front of them. Two of the residents left while the staff were away from the dining room; however, one resident remained at the table and continued to consume food and fluids. The resident attempted to get up from their chair; however, they were unable to do so. PSW staff returned to the dining area and it was observed that the resident was unable to safely transfer independently from their dining chair. Staff were not in the dining area, the Social Worker was not in their office (off the dining room) and staff were not available in the front Admission Coordinator's office. Residents were not monitored while eating and drinking during that time. [s. 73. (1) 4.] (107)

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

Jun 30, 2015

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

Linked to Existing Order / Lien vers ordre existant: 2014_278539_0013, CO #006;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Order / Ordre :

The licensee shall ensure that all menu items are prepared according to the planned menu. The licensee shall:
1. Review the home's food ordering processes to ensure all items are ordered and available and ordered in sufficient quantities to meet the menu requirements for all diet types and textures.
2. Provide education for staff preparing meals and snacks related to preparation of the planned menu according to standardized recipes/production sheets.
3. Review staff communication processes around product shortages and substitutions.
4. Implement quality management processes to monitor the provision of items according to the planned menu.

Grounds / Motifs :

1. Previously issued May 2014 as a CO

The licensee has failed to ensure that all menu items were prepared according to the planned menu at the lunch meal January 19, 2015.

A) The posted menu stated shaved pork on a bun with a corn cobbette and mandarin oranges for dessert or mushroom and Swiss cheese quiche, hash browned potatoes, marinated zucchini, and broken glass jellies.

B) Residents receiving a pureed texture menu were provided pureed squash and parsnips instead of the corn cobbette; pureed cold mixed vegetables with no marinade instead of the marinated zucchini; instant mashed potatoes instead of seasoned hash browned potatoes; pureed fruit cocktail instead of the mandarin oranges; and pureed pineapple instead of the broken glass jellies. The Cook and Nutrition Manager stated that the home usually used a purchased pureed corn product; however, the purchased corn was not ordered and they had extra squash/parsnip so that was substituted for the minced and pureed textured menus. The Cook stated they did not have enough zucchini for the pureed texture marinated zucchini so mixed vegetables with no marinade was substituted. The Nutrition Manager stated they were not made aware that there were insufficient quantities of zucchini and was unaware that a substitution had been made. The item that was supposed to be pureed mushroom Swiss quiche, that was served to residents for the first half of the meal on the second floor, was different than the pureed product sent

up at the end of the meal. The first product was thick and tasted like macaroni with no mushroom flavour and the second product tasted like cream of mushroom soup. The two items were different consistencies and different colours. The Cook was unable to state why the products appeared and tasted different and stated that sometimes the home used left overs for the pureed texture menu and it might have been a different type of quiche.

C) Residents receiving a minced texture menu were provided squash and parsnips instead of the corn cobette; and had mixed vegetables added to their marinated zucchini.

D) The recipe for the broken glass dessert required whipped topping to be added to strawberry jello. The dessert served to residents included only red and green jello.

E) Menu items were not prepared according to the planned menu.

The licensee failed to ensure all menu items were prepared according to the planned menu at the lunch meal January 28, 2015.

A) The menu required a sliced meat plate that contained sliced roast beef and sliced turkey. The minced textured meat plate was prepared with a combination of sliced deli turkey meat and diced cooked chicken (different textures and colours). The Cook was unable to state why they used two different meats except stating that the chicken was prepared the day prior so it was used. The meat plate was to be served with a dinner roll; however, insufficient quantities were available so sliced bread was substituted at the last minute.

B) The recipe for the hot dog included cheese; however, a cheese slice was not included on the hot dogs served to residents.

C) The menu identified tropical chiffon for dessert. Dietary staff confirmed banana pudding was served (was again served on the afternoon snack cart and at the following dinner meal).

D) The menu required pears as an alternate dessert choice for the renal menu. Staff confirmed the pears were not prepared or available for service. One resident in the identified dining area required a renal menu.

E) The menu required a 1/2 serving of a banana. A whole banana was served to residents and staff stated there were insufficient quantities to prepare the bananas for the minced and pureed texture. Tropical fruit was substituted for the minced and pureed menus which was not consistent with the planned menu.

The licensee failed to ensure that all menu items were prepared according to the planned menu at the dinner meal January 28, 2015.

A) The planned menu required cauliflower; however, lima beans were served as a substitution. (107)

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

Jul 31, 2015

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Order / Ordre :

The licensee shall ensure that all menu substitutions are communicated to residents.
The licensee shall:
1. Ensure there is a consistent process in place for communicating any menu substitutions or changes to residents.
2. Ensure quality management activities are in place to monitor the communication of any menu changes to residents.

Grounds / Motifs :

1. Previously issued August 2014 as a CO.

The licensee has failed to ensure that all menu substitutions were communicated to residents receiving a texture modified menu at the lunch meal January 19, 2015.

A) The posted menu stated shaved pork on a bun with a corn cobette and mandarin oranges for dessert or mushroom and Swiss cheese quiche, marinated zucchini, and broken glass jellies.

B) Residents receiving a pureed texture menu were provided pureed squash and parsnips instead of the corn cobette/creamed corn; pureed cold mixed vegetables with no marinade instead of the marinated zucchini; pureed fruit cocktail instead of the mandarin oranges; and applesauce instead of the broken glass jellies. Staff serving the desserts stated it was all pureed mandarin oranges and were not actually aware of what they were serving to residents. Staff serving and portioning also were unclear what the squash/parsnip mix was and what the orange vegetable was (pureed mixed vegetables). The substitutions were not communicated to staff serving nor to residents who were eating the items. The Nutrition Manager stated they were not made aware that some of the substitutions had been made. The item that was supposed to be mushroom Swiss quiche, that was served to residents for the first half of the meal was different than the pureed product sent up at the end of the meal. The first product was thick and tasted like macaroni with no mushroom flavour and the second product tasted like cream of mushroom soup. The two items were different consistencies and different colours. The Cook was unable to state why the products appeared and tasted different and stated that sometimes the home used left overs first for the pureed and it might have been a different type of quiche.

C) Residents receiving a minced texture menu were provided squash and parsnips instead of the corn cobette and had mixed vegetables added to their marinated zucchini.

D) The menu served to residents was not consistent with the planned menu and the substitutions were not communicated to staff and residents. (107)

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

Jun 30, 2015

Order # / Ordre no : 005 **Order Type / Genre d’ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_278539_0013, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the home protects residents from abuse by staff.

Grounds / Motifs :

1. Previously issued: March 2012 as a CO; October 2013 as a CO; May 2014 as a CO; August, 2014 as a CO

The licensee has failed to ensure that resident #047 was protected from abuse.

Resident #047 was seen crying. The resident told a PSW that they had been physically abused by a PSW. Review of the home's investigation notes identified that the Registered Nurse asked the resident if they knew who had hit them. The resident then pointed at a Personal Support Worker (PSW) who had entered the room. The staff was terminated following the home's investigation. On February 3, 2015, when resident #047 was questioned by the inspector, they were unable to recall the event; however, according to the home's investigations notes, resident #047 had been able to recall the details on a number of occasions, following the incident.

The Administrator confirmed that the same PSW had been involved in the incident with resident #047 as well as an incident where staff received a three day suspension in regards to neglect.

The home has indeed investigated, disciplined, and terminated the PSW involved; however, the home had not mitigated the risk as the staff's behavior had not changed. The home's training records identified that the PSW involved had not received annual abuse training in 2010, 2011 or 2012, nor did they have a police check on file. Despite the homes efforts, residents continued to be exposed to possible or potential abuse and neglect. [s. 19. (1)] (536)

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

May 15, 2015(A1)

Order # / Ordre no : 006

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

Linked to Existing Order / Lien vers ordre existant: 2014_278539_0013, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that outlines how the home will ensure that all food and fluids in the food production systems are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality.
The plan shall include, but is not limited to:
1. A review of the home's food ordering system to ensure that all items required for the preparation of the planned menu are available
2. A review of texture modified recipes to ensure they provide the same level of taste, nutritive value, appearance and food quality as the regular texture menu
3. Provide education for staff preparing meals and snacks related to the preparation of the menu according to standardized recipes and production sheets
4. Develop and implement a quality management system and schedule for monitoring the provision of food according to the planned menu and in a manner that preserves taste, nutritive value, appearance and food quality.

The plan shall be submitted by April 28, 2015 to Long Term Care Homes Inspector, Michelle Warrener, through e-mail to:
Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. Previously issued October 2014 as a CO; January 2013 as a WN; May 2011 as a VPC.

The licensee has failed to ensure that all food and fluids were prepared and served using methods that preserved taste, nutritive value, appearance and food quality.

A) At the lunch meal January 19, 2015, residents receiving a pureed menu received cold pureed mixed vegetables with their meal instead of the pureed marinated zucchini. The mixed vegetables served did not contain seasoning or sauce and the flavour and quality of the vegetables was not maintained by serving them cold. The nutritive value, taste, and quality of the pureed pork was reduced in comparison to the regular and minced texture pork. The regular texture and minced texture pork was flavourful and contained recognizable gravy added to the product; however, the pureed pork did not have any flavour and tasted like pork with water added only. The Cook stated that gravy was added to the pureed pork; however, the taste of the pureed texture pork was considerably less flavourful than the regular and minced textured pork.

B) At the lunch meal February 5, 2015, sherbet was served for dessert. The sherbet had previously melted in the nappies and was then re-frozen and served to residents. The appearance of the sherbet was not maintained (altered colour and consistency).

C) Skim milk was served with coffee and tea on the snack cart which did not preserve the taste of the beverage. Cream and 2% milk were not available. Dietary staff in the kitchen stated the coffee was not to be served with skim milk.

D) The recipe for fish cakes required tartar sauce for the regular texture, cream sauce for the minced texture and a brown gravy for the pureed texture. The same quality and taste were not maintained for the pureed texture fish cakes.

E) The recipe for pureed soup did not contain a thickener. The pureed soup provided to residents contained thickener for all residents. The taste and palatability of the soup was changed with the addition of thickener for those that did not require thickened soup. (107)

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

Jul 31, 2015

Order # / Ordre no : 007 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Order / Ordre :

The licensee shall ensure that all food is stored using methods that prevent adulteration and contamination. The licensee shall develop and implement a quality management system to monitor that foods are stored appropriately.

Grounds / Motifs :

1. Previously issued August 2014 as a CO

The licensee has failed to ensure that all food was stored using methods that prevented adulteration and contamination. Items in the dry storage area of the kitchen (cookies, crackers and dry ingredients) were stored in opened packages or boxes that were not sealed to prevent contamination/infestation and to keep the items fresh. Dietary staff confirmed that all packages were to be sealed or foods were to be transferred to a sealed container/bag after opening if the package could no longer be sealed. The home's Pest Management records for January 9, 2015, identified the traps were moved for activity near the peanut butter trays. (107)

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

Jun 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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
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 18 day of June 2015 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MICHELLE WARRENER - (A2)

Service Area Office /
Bureau régional de services : Hamilton