Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
May 24, 2016;	2014_322156_0016 (A1)	H-001251-14	Resident Quality Inspection

Licensee/Titulaire de permis

SHALOM VILLAGE NURSING HOME
60 MACKLIN STREET NORTH HAMILTON ON L8S 3S1

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

SHALOM VILLAGE NURSING HOME
70 MACKLIN STREET NORTH HAMILTON ON L8S 3S1

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

BERNADETTE SUSNIK (120) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance due date for Order #004 related to lighting was amended from December 31, 2015 to December 30, 2016.

Issued on this 24 day of May 2016 (A1)

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

Original report signed by the inspector.

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

BERNADETTE SUSNIK (120) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): September 29, 30, October 1, 2, 3, 7, 2014

This Inspection Report contains findings of non-compliance identified during inspections conducted concurrently with the Resident Quality Inspection. Concurrent Complaint Inspections include H-006627-14 and concurrent Critical Incident Inspections include H-000691-14, H-000702-14 and H-001121-14.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered staff, Registered Dietitian (RD), Dietary aides, cooks, Personal support workers (psw's), Clinical Education Coach, Director of Environmental Services, Housekeeping and Laundry Manager, Maintenance staff, residents and families

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

23 WN(s)
10 VPC(s)
4 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee did not ensure that the home was a safe environment for its residents.

All dining rooms were equipped with two steam wells (some portable) in the kitchens located within each dining room. The steam wells were noted to be accessible to residents in 7 out of the 8 dining rooms. Dietary staff were directed to turn on the steam wells 30-45 minutes prior to each meal service (as per notice posted on one wall in the Raven's Cliff kitchen). The staff would than leave the dining room to go and perform other duties. At the end of each meal, staff were required to turn off the steam wells. During the inspection on September 30, 2014, 2 steam wells were found to be on and steaming hot in the Gould kitchen more than 1.5 hours after the lunch meal. In the Raven's Cliff kitchen, both steam wells were steaming hot and no staff present on October 1, 2014 at approximately 11:20 a.m.
The Administrator was aware of the issue and had ordered several new steam table units which could be wheeled into the kitchens just before the meal service. However, no other alternatives had been implemented to reduce the potential for residents to access the hot steam tables and potentially burning themselves. [s. 5.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee did not ensure that all doors leading to stairways were equipped with an audible door alarm that allowed the call to be canceled only at the point of activation (at the door).

A) The first and second floors of the Shalom Village Original (SVO) building each had 3 doors leading to a stairwell equipped with an access control system; however the doors did not sound or alarm when held open for over 2 minutes. When the Director of Care was approached regarding the issue, he stated that a company had recently been in the home to install the new resident-staff communication and response system and they were also working on the connectivity of the doors to the system.

On the second day of inspection, several alarms were installed on several doors; however the installer did not have additional parts to complete the installation on all of the doors.

The licensee did not ensure that all doors to stairways were equipped with a door access control system that is kept on at all times.

A) Two basement doors to stairwells to which residents had access during the inspection were not equipped with any sort of locking mechanism or system or any audible door alarms. They were located next to the cafe and Rabbi's office. Not all stairwell doors were checked.

The licensee did not ensure that all doors that were equipped with a door access control system were kept on at all times or locked.

A) A set of double doors located in the basement which backed out onto a garbage disposal area was equipped with a access control system consisting of a key pad and magnetic plates. The key pad however was programmed to be on by-pass and the magnetic plates were not engaged or locked. Residents had full access to these doors and to the unsecured outdoor space.

The licensee did not ensure that the door between the SVO building and the apartments was connected to the resident-staff communication system (visual board) or equipped with an audible alarm at the door.

A) The door was tested and held open for over 60 seconds with no alarm or visual enunciator. The main lobby doors into the SVO main floor building are not used by visitors according to the Director of Care for the building. Visitors have been directed to go through a door leading to the apartments and to take a corridor to a single door leading to the SVO building. The door was observed to be heavily used and was equipped with a key pad to disengage the magnetic hold on a self closing device attached to the door for wheelchair accessibility. [s. 9. (1)]

2. The licensee did not ensure that balcony or courtyard doors located within various dining rooms located within the Shalom Village Original building, within the newer building occupied in 2004 and within the basement were equipped with locks to restrict unsupervised access to the secured outdoor areas.

A) The sliding courtyard and balcony doors were of the same design throughout the two buildings. The doors were equipped with a simple sliding lever to lock the doors; however the levers were easy to manipulate by residents and could access the outdoor space without staff knowledge. In the basement area, a family dining room had a french door with a simple twist lock on the door handle and the fitness or gym room had a door with a metal bar across it.

Doors to outdoor spaces are of a particular concern during the cold weather months and at night. The Director of Care identified that most of the courtyard and balcony doors were included in a recent project to have them alarmed and locked using a door access control system and that the installation of the system had not been completed. The home did not have any procedure or policy with respect to the use of the outdoor space, who would monitor residents and how often or who would check the doors and how often. [s. 9. (1) 1.1.]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee did not ensure that the lighting levels as set out in the lighting table were maintained throughout the long-term care home.

Lighting levels were measured using a portable hand held analog illumination meter in corridors, resident rooms, bathrooms, tub/shower rooms dining rooms and lounge areas in both buildings (SVO and SV TOO).

In the SVO or the Shalom Village Original building built approximately 40 years ago, lighting levels were non-compliant in all areas identified above. The part of the lighting table that was applied included the section titled "all other homes". In the SV Too or the Shalom Village building built in 2003, lighting levels were non-compliant only in certain corridors. The section of the lighting table that was applied included the

section titled "Homes to which the 2009 design manual applies".

A) SVO - Corridors

-comprised of 2 main corridors and a short corridor in front of the elevators on each of floors 1 and 2.
- 4 different styles of lighting fixtures provided on variable ceiling heights between 8-15 feet high.
- fixtures were spaced 2-6 feet apart
- lux levels were measured 3 feet above the floor level with meter parallel to the floor
- lux levels achieved were 110 to 150 where fluorescent lights provided and 20-50 lux where pot lights provided, well below the required minimum level of 215.28 lux. Eight corridor fixtures were burnt out in the Goldblatt corridor where the lux level was at zero.

B) SVO – lounge spaces

-main floor consisted of a lounge room off the main entrance to the building. The room was equipped with pot lights and fluorescent lights above a false ceiling. The lux at the entrance was 20 and 110 lux under the pot lights. The minimum required level is 215.28 lux.
-second floor lounge (music room), although the natural light could not be controlled for, the center of the room was only 110 lux and it was noted that no light fixtures were provided in the room. The minimum required level is 215.28 lux.

C) SVO - resident bathrooms

- Identified rooms were used as representative bathrooms (all rooms were noted to be equipped with the same light fixture and were the same size).
- comprised of one light fixture mounted on the wall over the vanity
- 175 lux over the sink area and 110 lux over the toilet area in an identified room. 200 lux over the vanity and 100 lux over the toilet area in another identified room. Lux levels were different due to age of bulbs. Below the minimum required level of 215.28 lux.

D) SVO - resident bedrooms

- Identified rooms were used as representative bedrooms for a private room and a semi-private room. All private and semi-private bedrooms were noted to be equipped

with the same light fixtures and were the same size. The only difference was the height of the ceiling, being much higher on the first floor.
- on the first floor, bedrooms had two ceiling heights, one lower upon entry equipped with round flush mounted fixture and bedroom ceiling approximately 15 feet high equipped with a round flush mounted light close to the centre of the room in the private rooms and over each bed in the semi-private rooms.
- cloudy conditions noted outdoors, blinds closed to block out natural light to mimic night time conditions and all light fixtures (excluding resident lamps) in the room turned on and left to burn for 5 minutes before testing.
- residents were not provided with over bed lighting or reading lamps in the Zucker or Gould home areas. Each resident was observed to have their own personal reading lamp which was not provided by the licensee. The Goldblatt home area had a lamp and shade attached to a swing arm which was attached to the wall near the bed in some of the rooms. Some of the lamps were not in working order.
- lux directly under bedroom light in an identified room was 20. The lux under one of the ceiling lights in another identified room was 110. The lux on either side of the bed was 50 and 160 lux at the head of the bed in the reading position. The minimum required level for general room light is 215.28 lux (in and around areas of the bed and in areas of the room where activities of daily living occur). The lux level required for the head of the bed and when the bed is in the reading position is 376.73.

E) SVO – Dining rooms

-the dining rooms located in the Goldblatt and Zucker home areas were used as representative dining rooms
- Each dining room was equipped with a kitchen area, sitting area and dining area. The lighting fixtures consisted of wall sconces, hanging pendant lights (not in all dining rooms), track spot lights and round flush mounted ceiling lights. Many of the light fixtures were noted to be burnt out in the various dining rooms, contributing to poor overall lighting levels.
- Blinds were not pulled; however light levels at the windows did not affect light levels within the room. The natural light at the windows was 400 lux. When the lights were measured over and around the tables and the seating area, the lux ranged from 50-270 lux. The lighting level required at the tables and in sitting areas is 215. 28 lux.

F) SVO – tub rooms

-Goldblatt shower area had a burnt out light and the lux for the shower area was zero.

G) SVO Too – Corridors

-the corridors on both 1st and 2nd floors in general did not provide the consistent and continuous level of 322.92 lux due to the layout of the fixtures. The fixtures, depending on the age of the bulb ranged from 150-500 lux, but because of the spacing between fixtures, the lux dropped to 20-190 lux.
-Oak Knoll – 1 corridor in particular was equipped with recessed fluorescent tubes with a metal lens that were spaced 10 feet apart and were not positioned centrally along the corridor as they were in other corridors. The lux level was 150 under the light and 20 lux between fixtures. Near the Oak Knoll nurse's station, no lighting fixtures were provided in the corridor between the hall windows and the end of the nurse's station. The distance was 12 feet between fixtures and the lux was 20. The lux was only 150 lux under the lights on either side of the nurse's station. The exact area on the 2nd floor was equipped with a light fixture, however the minimum level was also not achieved with the extra fixture and with the lights on in the nurse's station.
-Mayfair Place – corridor outside the dining room was equipped with recessed fluorescent tubes with a metal lens which were spaced 8 feet apart. One light was 400 lux and another light was 500 lux. The amount of light in between these lights was 190 lux.
-Several corridor and tub room lights were noted to be burnt out on each floor. [s. 18.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 004

WN #4: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

s. 6. (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 provide direct care to the resident.

The plan of care for resident #11 indicated that the resident was to have a specific intervention in place. During the course of the inspection, the intervention was not found to be in place. Front line staff reported on October 1, 2104 that the intervention was only used at a specific time. The plan of care did not set out clear directions to staff as it did not specify when to use the intervention. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

The plan of care for resident #6 indicated that the resident preferred to go to bed at 1930 hours; however, during interview in Stage One on September 30, 2014 and

subsequent interview with the resident on October 2, 2014, the resident indicated that their preference was to go to bed at 2030 hours unless feeling unwell. The plan of care was not based on an assessment of the preferences of the resident. [s. 6. (2)]

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

The MDS assessment for resident #11 dated July 6, 2014 Section J, 4 indicated that the resident had a fall in the past 180 days but did not indicate a fall had occurred in the past 30 days. The progress notes indicated that the resident had a fall and was assessed post fall in on two identified days in June, 2014. Interview with the RAI coordinator confirmed that there was a coding error with the MDS assessment as there had been two falls in the past 30 days. The assessments were not found to be integrated, consistent and complement each other. [s. 6. (4) (a)]

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

A) In May 2014, two psw's assisted resident #30 with dressing and lifted the resident from a chair to the bed. The following day the resident reported that they thought staff were "tearing off" the resident's clothes and forcing the resident to bed.
Review of the plan of care indicated that the resident required extensive assistance for transferring and dressing. Due to increased pain and anxiety, interventions for staff included but were not limited to: providing alternate rest and segment of dressing by breaking dressing process into subtasks and giving one instruction at a time, and to be gentle and provide word of comfort throughout.

Interview with the Administrator and DOC confirmed that the staff did not provide the resident with enough instruction nor did they break up dressing into segments, as outlined in the plan of care; as a result the resident was unaware of staff's intentions.

B) The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.
The care plan for resident #11 indicated that the resident was at risk for falls and that a specific intervention was to be used. During interview with front line staff on October 1, 2014, it was reported that the resident did not have the intervention and therefore did not use it. On this day, the resident also reported that they did not have the specific intervention . The plan of care was not provided to the resident as specified in

the plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident, that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident, that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other and that the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used the resident was assessed and his or her bed system was evaluated to minimize risk to the resident.

Residents #5, #6, #10, #11 and #13 were not assessed for use of the PASD bed rail to minimize the risks to the resident. Through observation and interview with staff it was confirmed that all of these residents used the bed rails when in bed for positioning and safety. Review of the plans of care of the above residents did not include a formalized assessment of bed rail risk.
The Administrator and DOC confirmed during interview on October 3, 2014 that formalized assessments were not completed related to the use of bed rails. The residents had not been assessed and his or her bed system evaluated to minimize risks to the residents. [s. 15. (1) (a)]

2. The licensee failed to ensure that where bed rails were used that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident # 6 was assessed for potential bed entrapment in July 2013; however failed zone 2 for risk of entrapment.

Resident # 11 was assessed for potential bed entrapment in July 2013; however failed zones 2 and 4 for risk of entrapment.

Interview with the DOC on October 7, 2104 confirmed that changes were made to both bed systems in attempt to correct failed zones of entrapment, however, bed systems were not reassessed to ensure they passed for all potential zones of entrapment. Steps were not taken to prevent resident entrapment including all potential zones of entrapment.
Further, no bed accessories were used to mitigate risk such as bolsters, bed rail pads or gap fillers.

Critical Incident submitted in October, 2014 provided further evidence of entrapment risk. Resident #100 was found with their arm trapped between the mattress and bed rail in October, 2104. [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 to ensure that where bed rails were used the resident was assessed and his or her bed system was evaluated to minimize risk to the resident and that where bed rails were used that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #6: 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 promotes zero tolerance of abuse and neglect of residents and that it was complied with.

The homes policy "Prevention of Resident Abuse and Neglect", last revised August 2014, stated that every alleged, suspected or witnessed incident of abuse MUST be immediately investigated. The CEO must be informed by either the Coach or the On Call if the allegation occurred "after hours". The Coach or designate MUST immediately submit a Critical Incident Report via the electronic CIS system.

A) In May, 2014 resident #30 reported to staff that two psw's woke the resident up in the wheelchair by "tearing off" the resident's clothes and staff were "hurting" the resident while removing the clothes, and the resident was "forced to go back to bed" too early. Review of the clinical health record included a progress note from the DOC about the incident in May, 2014 and investigative actions. The information regarding resident #30's allegations of staff to resident abuse were not submitted to the Director until a later date in May, 2014; the MOHLTC was not immediately notified of the abuse allegations.

B) In May, 2014, resident #31 reported to staff that a co-resident touched the resident inappropriately the day before. The incident was immediately investigated by the home; however the CIS was not submitted until an identified date in June, 2014. Interview with Administrator and DOC confirmed that the allegations of abuse from resident #31 were not reported immediately, as outlined in the home's "Prevention of Abuse and Neglect Policy" [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 to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care. According to s. 33 (4) 4. The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if the use of the PASD has been consented to by the resident.
The plans of care for residents #6, #10, #11 and #13 indicated that the residents required the use of a bed rail PASD (Personal Assistance Services Device) for mobility. Review of the plans of care did not include a consent for the use of the PASD bed rail. The Administrator confirmed on October 3, 2014 that the use of the PASD's were not consented to. [s. 33. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care. According to s. 33 (4) 4. The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if the use of the PASD has been consented to by the resident, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting the resident.

A) In October, 2013, resident #4 fell during a transfer using a SARA lift, only one psw was present during the transfer.
i. The Annual Minimum Data Set (MDS) assessment from October 1, 2013, indicated the resident required extensive assistance of two persons for transfers and toileting.
ii. Review of the progress notes revealed the resident presented with new symptoms of fever and lethargy the day prior to the fall.
iii. The home's policy on "Use of Mechanical Lifts", last revised December 2013 stated that when a resident uses the SARA lift, one or two staff persons need to be present depending on the strength and ability of the residents to use the SARA lift. This assessment is conducted by the physiotherapist in conjunction with the Registered Nursing staff and transferring directions are documented in the care plan or Kardex.
iv. The document the home refers to as the care plan instructed staff to use the hoyer lift for safe transferring of the resident, as assessed by physiotherapy in July, 2013.

Noting the resident's new symptoms of fever and lethargy, most recent physiotherapy and MDS assessments prior to the fall, and the directions for staff in the plan of care; the psw did not use safe transferring techniques on an identified date in October, 2013 . Interview with the Administrator confirmed that the PSW did not use safe transferring techniques when transferring resident #4 in October, 2013. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff used safe transferring and positioning devices or techniques when assisting the resident, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds been assessed by a registered dietitian who was a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration implemented.

A) Resident #7 was to have a new area of altered skin integrity, which was assessed by registered staff, also assessed by the RD. Review of the plan of care did not include an assessment by the RD. In an interview with the Clinical Education Coach it was confirmed that a referral was not sent to the RD in August, 2014 and therefore the resident was not assessed by the RD. [s. 50. (2) (b) (iii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds been assessed by a registered dietitian who was a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration implemented, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee did not ensure that measures were in place to prevent the transmission of infections.

The transmission of infections may occur directly, from person to person, or indirectly, from contaminated products (creams), equipment, objects or articles shared by multiple persons to other persons. When articles are not dedicated or not adequately cleaned and disinfected between use, organisms living on the surfaces of the articles spread to the person using the article. Cleaning, disinfection and proper storage of the articles prevents or reduces the spread of disease causing organisms and therefore infections.

A) During the inspection, 6 tub rooms were observed to be missing tub cleaning brushes, an essential component to ensure tub surfaces are adequately cleaned. Four of the tubs were very dusty and psw's identified that they do not use certain tubs. Some personal care articles such as bed pans and wash basins were not clean in appearance, stored inappropriately, not specifically dedicated and did appear to have been cleaned or disinfected between use. Jars of zinc cream were found in communal spaces (shower rooms, care carts) with evidence of use and no indication who the jar of cream belonged to. Unlabeled hairbrushes, nail clippers and used

deodorant sticks were also observed in communal spaces (Mayfair Shower, Goldplatt care cart and Effort Square shower). Wash basins were observed to be stored on grab bars behind toilets in but not limited to eight identified rooms. A basin in an identified room washroom and a bed pan in two identified washrooms were not clean in appearance on September 30 and October 2, 2014. Names on some of the basins were worn out or had multiple names scratched out on them and they were stored in bathrooms with more than one resident using them. In an identified room washroom, a bed pan was noted to have the name of a resident on it that did not reside in the room.

According to a Director of Care, it was an expectation that the psw's ensure that all articles be labeled accordingly and kept with the resident. According to the home's policy and procedure identified as "Section 30 - Cleaning Equipment" dated May 2012, the staff in the home were to use a liquid cleaner and disinfectant first, followed by using a disposable wipe called Ultra Swipes Plus on "care equipment" between resident use. It was not clear in the procedure how exactly articles such as bed pans and wash basins were to be handled and cleaned; especially if heavily soiled. No mention was made where the "care equipment" would be cleaned (resident room, washroom or soiled utility room) or where the staff would access and store the disinfectant products. The policy did not include how "care equipment" would be stored after it was cleaned. The policy did not reflect that the home had 4 cleaning or disinfection machines that psw's reported using to clean articles.

During the inspection between September 30 and October 2, 2014, only 2 containers of Ultra Swipes Plus were seen throughout the homes known as SVO and SVToo. Both of the containers were almost empty and had expiry dates of 2013 on them. Staff therefore did not have the designated product in which to disinfect the articles. The required liquid disinfectant was identified in the shower/tub rooms of Effort Square, Goldblatt and Gould home areas and a bottle on a care cart located in the Mayfair Place home area. The other home areas had no disinfectant readily accessible to staff. According to psw's, the liquid disinfectant found in the shower rooms was used on shower chairs but was not consistently used by all staff after each use of the shower chairs. Another psw stated that they occasionally used the liquid disinfectant on wash basins and urinals but was required to get a key to the housekeeping closet to retrieve the liquid disinfectant. Other discussions identified that staff collect the basins and bedpans on the night shift and put them through a machine which washes and disinfects the articles. However, only one machine was available on each floor for a total of 4 machines out of 8 home areas. One of the disinfection machines used by staff from both the Weiz and Zucker home areas was not

operational for over a week (waiting for a part on order). One part time PSW did not know how to use one of the machines and none of the soiled utility rooms had any instructions on how to use the machine to ensure proper disinfection. No back up cleaning and disinfection process was identified for staff should a machine not be functional. None of the 8 soiled utility rooms had any disinfection products available for use by staff or cleaning instructions. [s. 86. (2) (b)]

Additional Required Actions:

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

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee did not ensure that hazardous substances were kept inaccessible to residents at all times on September 30, October 1, and October 2, 2014.

Six out of the eight kitchens located in resident accessible dining rooms had concentrated sanitizer stored under the sink in unlocked cabinets. The cabinets were equipped with key locks but were not locked. [s. 91.]

Additional Required Actions:

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

WN #12: 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 is 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 are required to prevent further occurrences as evidenced by:

The Director of Care (DOC) was interviewed and confirmed that in 2013, the home did not conduct an evaluation to determine the effectiveness of the policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences. [s. 99. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that at least once in every calendar year, an evaluation is 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 are required to prevent further occurrences, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use.

A) On October 7, 2014 at 0810 hours, the medication room located on the first floor of Shalom Village One tower, was noted to be unlocked and unattended. At that time two residents were noted to be seated in the resident lounge in front of the medication room door, and the registered staff was administering medications to residents in their rooms. Interview with registered staff confirmed that she left the medication room unlocked when she started morning medication administration, but it should have been locked. [s. 130. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the Fall Prevention and Management Program policy revised on September 16, 2014 was complied with.

The Fall Prevention and Management Program policy indicated that the At Home leader would complete the fall risk assessment and determine the resident's level of risk as low, moderate or high. Any risk should be care planned and treated.

The Administrator confirmed during interview on October 3, 2014 that the care plans should be resident specific and identify risk levels and that they currently did not.
A) Resident #6 was assessed on August 3, 2014 as being at moderate risk for falls; however, as of October 3, 2014, the care plan focus did not identify the risk levels for the resident for these care areas.
B) Resident #50 was assessed on May 20, 2014 as being at moderate risk for falls; however as of October 3, 2014, the care plan focus did not identify the risk levels for the resident for these care areas.
C) Resident #11 was assessed on June 30, 2014 as being at high risk for falls; however as of October 1, 2014, the care plan focus did not identify the risk levels for the resident for these care areas. [s. 8. (1)]

WN #15: 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 program was evaluated and updated at least annually in accordance with evidence-based practices and, if there is none, in accordance with prevailing practices.

The inspector requested that the home provide the record of the home's 2013 evaluation of the Fall Prevention and Management Program. The Director of Care (DOC) reported that the home did not evaluate the Fall Prevention and Management Program in 2013.

The home failed to evaluate and update the Fall Prevention and Management Program in 2013. [s. 30. (1) 3.]

WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations as evidenced by:

The 2014, Residents' Council Meeting Minutes of both the old and the new building home areas were reviewed. The records included the Administrator's response to the Residents' Council concerns for February, June and August, 2014. The other concerns of the Residents' Council were responded to by the department heads.

The Administrator was interviewed and confirmed that they did not respond in writing within 10 days of receiving Residents' Council advice related to all concerns or recommendations. The department heads did provide some of the written responses to the concerns of the Residents' Council.

The home failed to ensure that the Administrator responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations. [s. 57. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that their procedures developed to address the cleaning of dining room chairs were implemented. The surfaces of more than 50% of the dining room chairs (seats, frames) were heavily soiled throughout the day on September 30 and October 1, 2014 in the Raven's Cliff and Mayfair dining rooms. According to the Housekeeping Supervisor, the chairs are required to be cleaned daily. [s. 87. (2) (a)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that procedures were developed for routine, preventive and remedial maintenance in common areas of the home. Procedures were available for maintenance staff which described the work that was required of them for the home's operational systems (central heating, cooling, ventilation, hot water, fire systems), resident-staff communication and response system, generator, incremental cooling units, roof, elevators, lighting, doors, some equipment and resident room furniture and surfaces. However, procedures were not developed for interior surfaces (walls, floors, counters, ceilings, windows, cabinets, furniture and fixtures) in common areas such as dining rooms, lounges, tub and shower rooms, kitchens, sitting areas etc.

During the inspection, the following negative outcomes were identified, some of which were in the process of being addressed but no specific time dates of implementation provided;

A) Corroded plumbing fixtures in some resident bathrooms, soiled utility rooms and tub rooms. Hard water scale was observed on the fixtures. The Housekeeping Supervisor reported that a program was in place to try and remove the scale; however the effort had not been effective. The Administrator reported that plans were underway to replace the fixtures, but no set dates were provided.
B) The cabinet shelf under the sink in the Oak Knoll Kitchenette was eroded and no longer tight-fitting and easy to clean.
C) The laminate counter top around the steam wells in Oak Knoll and Raven's Cliff kitchenettes were eroded with exposed particle board pieces flaking off. The areas could not be cleaned.
D) Rusty toilet paper holders and electric base board heater covers were observed in the original building and over bed tables (bases) and floor lift (bases) were observed in both buildings.
E) Flooring material was missing or had de-laminated in certain dining rooms in both buildings. The Administrator noted that these areas have been identified and were slated to receive new flooring material. The date of installation was not provided during inspection. [s. 90. (1) (b)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee had written complaint procedures in place that incorporated the requirements set out in section 101 for dealing with complaints as evidenced by:

The home's complaint procedure Process for obtaining Information, Raising a Concern or Recommending Change, Revised September, 2014 was reviewed and included: "All complaints received will be documented, including a description of the issue, the date and follow-up action. All complaints will be investigated, and resolved within 10 business days, for complaints that cannot be resolved within 10 business days, an acknowledgment of receipt of the complaint shall be provided within 10 business days, this will include the date by which the complaint is expected to be resolved. A copy of all written complaints will be submitted to the director, along with the written report documenting the response and resolution. This will be submitted immediately after the completion of the investigation and resolution of the complaint."

The home's written procedures did not incorporate all of the requirements set out in section 101 (1) 1 including: where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

The home's written procedures for dealing with complaints did not incorporate all of the requirements set out in section 101. [s. 100.]

WN #20: 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. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant as evidenced by:

The Director of Care (DOC) was interviewed on October 2, 2014 at 1620 hours and reported that the home now has a new policy and procedures related to Reporting and Complaints which is approximately one month old. The Inspector requested the home's 2014 Complaint Record; however, the DOC explained that prior to September, 2014 the home did not have a Complaint Record to track concerns/complaints received by the home. It was explained that there was no record or log prior to September 2014 of the complaints or concerns listing all the concerns that the home received, date received and what actions that were taken to address the concerns. The DOC confirmed that she was responsible for dealing with all the complaints and concerns received by the home and that prior to September, 2014 all complaints or concerns would be reported to her, dealt with and copies of written complaints or concerns were placed in the individual resident's record and kept in a file in the office. There was no one record or log of all the complaints or concerns available listing all the written concerns that the home received prior to September, 2014. The home is currently working on the new computerized complaint record. [s. 101. (2)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the licensee informed the Director no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

An identified resident #13 fell on two identified dates in January, 2014. The resident was sent to hospital as a result of the injuries sustained from the falls and was found to have an injury. The home did not inform the Director of the fall incidents that caused the injury to the resident and which resulted in a significant change in the resident's health condition.

The Administrator and Director of Care were interviewed and confirmed that the home did not inform the Director of the occurrence of the fall incidents that caused an injury to the resident that resulted in a significant change in the resident's health condition and for which the resident was taken to the hospital. They reported that the home will inform the Director after identification by the inspector in October, 2014. [s. 107. (3) 4.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 216 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, at least annually, the program was evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices as evidenced by:

The home's Clinical Education Coach was interviewed and reported that in 2013 the home did not evaluate the education program. The DOC was interviewed and confirmed the above.

The home did not evaluate and the training and orientation program in 2013. [s. 216. (2)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 305. Construction, renovation, etc., of homes

Findings/Faits saillants :

1. The licensee did not ensure that they received approval of the Director before commencing any alterations or renovations to the home.

Contractors were observed installing sprinkler heads in resident rooms at the time of inspection in the building that is called Shalom Village Original (SVO). The work required some inconvenience to residents as they could not be in their rooms for approximately one hour. Secondly, the resident-staff communication and response system was observed to be replaced with a new system in the SVO building. The Director of Care confirmed that the system had just been installed throughout August and September 2014. Thirdly, the corridor carpeting on the first floor of the long-term care home located in an adjoining building to the SVO was replaced with vinyl material several months prior to the inspection.

The Administrator confirmed that no project plans had been submitted to the Ministry of Health and Long Term Care for approval of the above noted alterations to the home. [s. 305.]

Issued on this 24 day of May 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : BERNADETTE SUSNIK (120) - (A1)

Inspection No. / No de l'inspection : 2014_322156_0016 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-001251-14 (A1)

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

Report Date(s) / Date(s) du Rapport : May 24, 2016;(A1)

Licensee / Titulaire de permis : SHALOM VILLAGE NURSING HOME
60 MACKLIN STREET NORTH, HAMILTON, ON, L8S-3S1

LTC Home / Foyer de SLD : SHALOM VILLAGE NURSING HOME
70 MACKLIN STREET NORTH, HAMILTON, ON, L8S-3S1

Name of Administrator / Nom de l'administratrice ou de l'administrateur : JEANETTE O'LEARY

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To SHALOM VILLAGE NURSING HOME, 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee shall prepare and submit a plan that summarizes how hot appliances capable of causing injury to residents will be managed within the 8
kitchens located in the dining rooms so that residents do not have access to them.
The plan shall be submitted to Bernadette.susnik@ontario.ca by November 28,
2014.
The plan shall be implemented by December 31, 2014.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee did not ensure that the home was a safe environment for its residents. All dining rooms were equipped with two steam wells (some portable) in the kitchens located within each dining room. The steam wells were noted to be accessible to residents in 7 out of the 8 dining rooms. Dietary staff were directed to turn on the steam wells 30-45 minutes prior to each meal service (as per notice posted on one wall in the Raven's Cliff kitchen). The staff would than leave the dining room to go and perform other duties. At the end of each meal, staff were required to turn off the steam wells. During the inspection on September 30, 2014, 2 steam wells were found to be on and steaming hot in the Gould kitchen more than 1.5 hours after the lunch meal. In the Raven's Cliff kitchen, both steam wells were steaming hot and no staff present on October 1, 2014 at approximately 11:20 a.m.

The Administrator was aware of the issue and had ordered several new steam table units which could be wheeled into the kitchens just before the meal service. However, no other alternatives had been implemented to reduce the potential for residents to access the hot steam tables and potentially burning themselves. (120)

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

Dec 31, 2014

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. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee shall prepare and submit a plan that identifies when all of the doors
that lead to a balcony or to an enclosed or secured courtyard will be equipped
with a lock that residents cannot unlock without staff knowledge or staff intervention.
The plan shall be submitted to Bernadette.susnik@ontario.ca by November 28,
2014.
The plan shall be implemented by December 31, 2014.

Grounds / Motifs :

1. The licensee did not ensure that balcony or courtyard doors located within various dining rooms located within the Shalom Village Original building, within the newer building occupied in 2004 and within the basement were equipped with locks to restrict unsupervised access to the secured outdoor areas.

The sliding courtyard and balcony doors were of the same design throughout the two buildings. The doors were equipped with a simple sliding lever to lock the doors, however the levers were easy to manipulate by residents and could access the outdoor space without staff knowledge. In the basement area, a family dining room had a french door with a simple twist lock on the door handle and the fitness or gym room had a door with a metal bar across it.

Doors to outdoor spaces are of a particular concern during the cold weather months and at night. A Director of Care identified that most of the courtyard and balcony doors were included in a recent project to have them alarmed and locked using a door access control system and that the installation of the system had not been completed. The home did not have any procedure or policy with respect to the use of the outdoor space, who would monitor residents and how often or who would check the doors and how often. (120)

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Dec 31, 2014

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee shall prepare and submit a plan that identifies what sections of the basement will be made inaccessible to long term care residents and how those sections will be made secure to prevent residents from gaining access to stairwells and unsecured outdoor areas of the home. The plan shall also include when the door between the Shalom Village Original building and the apartments will be equipped with an alarm at the door and be connected to the visual enunciator currently in use at the home.
The plan shall be submitted to Bernadette.susnik@ontario.ca by November 28, 2014.
The plan shall be implemented by December 31, 2014.

Ontario

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

Grounds / Motifs :

1. The licensee did not ensure that all doors leading to stairways were equipped with an audible door alarm that allowed the call to be canceled only at the point of activation (at the door).
The licensee did not ensure that all doors to stairways were equipped with a door access control system that is kept on at all times. Two basement doors to stairwells to which residents had access during the inspection were not equipped with any sort of locking mechanism or system or any audible door alarms. They were located next to the cafe and Rabbi's office. Not all stairwell doors were checked.
The licensee did not ensure that all doors that were equipped with a door access control system were kept on at all times or locked. A set of double doors located in the basement which backed out onto a garbage disposal area was equipped with a access control system consisting of a key pad and magnetic plates. The key pad however was programmed to be on by-pass and the magnetic plates were not engaged or locked. Residents had full access to these doors and to the unsecured outdoor space.
The licensee did not ensure that the door between the SVO building and the apartments was connected to the resident-staff communication system (visual board) or equipped with an audible alarm at the door. The door was tested and held open for over 60 seconds with no alarm or visual enunciator. The main lobby doors into the SVO main floor building are not used by visitors according to the Director of Care for the building. Visitors have been directed to go through a door leading to the apartments and to take a corridor to a single door leading to the SVO building. The door was observed to be heavily used and was equipped with a key pad to disengage the magnetic hold on a self closing device attached to the door for wheelchair accessibility.
(120)

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

Dec 31, 2014

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Order / Ordre :

(A1)
The licensee shall prepare and submit a plan that summarizes when the lighting levels in the home will be addressed to
ensure that all other areas meet the minimum guidelines as outlined in the lighting Table under "all other homes".

The plan shall be submitted to Bernadette.susnik@ontario.ca by September 31, 2016.
The plan shall be implemented by December 30, 2016 unless prior notification is received in writing to extend the compliance date.

Grounds / Motifs :

1. The licensee did not ensure that the lighting levels as set out in the lighting table were maintained throughout the long-term care home.
Lighting levels were measured using a portable hand held analog illumination meter in corridors, resident rooms, bathrooms, tub/shower rooms dining rooms and lounge areas in both buildings (SVO and SV Too).

In the SVO or the Shalom Village Original building built approximately 40 years ago, lighting levels were non-compliant in all areas identified above. The part of the lighting table that was applied included the section titled "all other homes". In the SV Too or the Shalom Village building built in 2003, lighting levels were non-compliant only in certain corridors. The section of the lighting table that was applied included the section titled "Homes to which the 2009 design manual applies".

SVO - Corridors
- comprised of 2 main corridors and a short corridor in front of the elevators on each of floors 1 and 2.
- 4 different styles of lighting fixtures provided on variable ceiling heights between 8-15 feet high.
- fixtures were spaced 2-6 feet apart
- lux levels were measured 3 feet above the floor level with meter parallel to the floor
- lux levels achieved were 110 to 150 where fluorescent lights provided and 20-50 lux where pot lights provided, well below the required minimum level of 215.28 lux. Eight corridor fixtures were burnt out in the Goldblatt corridor where the lux level was at zero.

SVO – lounge spaces
-main floor consisted of a lounge room off the main entrance to the building. The room was equipped with pot lights and fluorescent lights above a false ceiling. The lux at the entrance was 20 and 110 lux under the pot lights. The minimum required level is 215.28 lux.
-second floor lounge (music room), although the natural light could not be controlled for, the center of the room was only 110 lux and it was noted that no light fixtures were provided in the room. The minimum required level is 215.28 lux.

SVO - resident bathrooms
-Identified rooms were used as representative bathrooms (all rooms were noted to be equipped with the same light fixture and were the same size).
- comprised of one light fixture mounted on the wall over the vanity
- 175 lux over the sink area and 110 lux over the toilet area in an identified room. 200 lux over the vanity and 100 lux over the toilet area in another identified room. Lux levels were different due to age of bulbs. Below the minimum required level of 215.28 lux.

SVO - resident bedrooms
- Identified rooms were used as representative bedrooms for a private room and a semi-private room. All private and semi-private bedrooms were noted to be equipped with the same light fixtures and were the same size. The only difference was the height of the ceiling, being much higher on the first floor.
- on the first floor, bedrooms had two ceiling heights, one lower upon entry equipped with round flush mounted fixture and bedroom ceiling approximately 15 feet high equipped with a round flush mounted light close to the centre of the room in the private rooms and over each bed in the semi-private rooms.
- cloudy conditions noted outdoors, blinds closed to block out natural light to mimic night time conditions and all light fixtures (excluding resident lamps) in the room turned on and left to burn for 5 minutes before testing.
- residents were not provided with over bed lighting or reading lamps in the Zucker or Gould home areas. Each resident was observed to have their own personal reading lamp which was not provided by the licensee. The Goldblatt home area had a lamp and shade attached to a swing arm which was attached to the wall near the bed in some of the rooms. Some of the lamps were not in working order.
- lux directly under bedroom light in an identified room was 20. The lux under one of the ceiling lights in another identified room was 110. The lux on either side of the bed was 50 and 160 lux at the head of the bed in the reading position. The minimum

required level for general room light is 215.28 lux (in and around areas of the bed and in areas of the room where activities of daily living occur). The lux level required for the head of the bed and when the bed is in the reading position is 376.73.

SVO – Dining rooms
-the dining rooms located in the Goldblatt and Zucker home areas were used as representative dining rooms
- Each dining room was equipped with a kitchen area, sitting area and dining area. The lighting fixtures consisted of wall sconces, hanging pendant lights (not in all dining rooms), track spot lights and round flush mounted ceiling lights. Many of the light fixtures were noted to be burnt out in the various dining rooms, contributing to poor overall lighting levels.
- Blinds were not pulled, however light levels at the windows did not affect light levels within the room. The natural light at the windows was 400 lux. When the lights were measured over and around the tables and the seating area, the lux ranged from 50-270 lux. The lighting level required at the tables and in sitting areas is 215. 28 lux.

SVO – tub rooms
-Goldblatt shower area had a burnt out light and the lux for the shower area was zero.

SVO Too – Corridors
-the corridors on both 1st and 2nd floors in general did not provide the consistent and continuous level of 322.92 lux due to the layout of the fixtures. The fixtures, depending on the age of the bulb ranged from 150-500 lux, but because of the spacing between fixtures, the lux dropped to 20-190 lux.
-Oak Knoll – 1 corridor in particular was equipped with recessed fluorescent tubes with a metal lens that were spaced 10 feet apart and were not positioned centrally along the corridor as they were in other corridors. The lux level was 150 under the light and 20 lux between fixtures. Near the Oak Knoll nurse's station, no lighting fixtures were provided in the corridor between the hall windows and the end of the nurse's station. The distance was 12 feet between fixtures and the lux was 20. The lux was only 150 lux under the lights on either side of the nurse's station. The exact area on the 2nd floor was equipped with a light fixture, however the minimum level was also not achieved with the extra fixture and with the lights on in the nurse's station.
-Mayfair Place – corridor outside the dining room was equipped with recessed fluorescent tubes with a metal lens which were spaced 8 feet apart. One light was

400 lux and another light was 500 lux. The amount of light in between these lights was 190 lux.
-Several corridor and tub room lights were noted to be burnt out on each floor. (120)

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

Dec 30, 2016(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

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

Issued on this 24 day of May 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK - (A1)

Service Area Office /
Bureau régional de services : Hamilton