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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 23, 2013	2012_103193_0012	T-2116-12	Resident Quality Inspection

Licensee/Titulaire de permis

UNIONVILLE HOME SOCIETY
4300 Highway #7, MARKHAM, ON, L3R-1L8

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

UNION VILLA
4300 Highway #7, Unionville, ON, L3R-1L8

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

MONICA NOURI (193), LYNN PARSONS (153), TIINA TRALMAN (162)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): nt Quality Inspection inspection.

November 19, 20, 21, 23, 26, 27, 28, 30, and December 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 2012.

During the course of the inspection, the inspector(s) spoke with President and CEO, Director of Long Term Care Operations, Director of Nursing and Personal Care (DNPC), RAI-MDS Coordinator, Unit Nurse Managers, Registered Dietitian, Food Service Manager, Food Service Workers, Physiotherapist, Physiotherapist Assistant, Pharmacist, Recreation and Social Activities Supervisor and Staff, Environmental Services Manager, Housekeeping Staff, Accountant, Education Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Residents and Families.

During the course of the inspection, the inspector(s) toured the home, reviewed residents' health records, the licensee's policies and procedures, training records, staff immunization, observed provision of care and staff-resident interactions, meal service.
The following complaints logs were inspected during this Resident Quality Inspection;
#T-2685-11, #T-2753-11, #T-0067-12, #T-00123-12, #T-00382-12, #T-00388-12, #T-00414-12, #T-00426-12, #T-1102-12, and #T-1193-12.
The following Critical Incident Reports logs were inspected during this Resident Quality Inspection;
#T-1152-11, #T-2197-12, #T-2196-12, #T-0935-12,and #T-1133-12.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation
Falls Prevention
Family Council
Hospitalization and Death
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Reporting and Complaints
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to provide training to all staff who provide direct care to residents as follows:
a) falls prevention and management
Through interviews with front line staff and the Education Coordinator it was determined that not all all staff who provide direct care to residents received the training for falls prevention and management as follows:
- 54/160 (33%) of the staff who provide direct care received the training in 2011, and
- 83/140 (59%) of the staff who provide direct care received the training up to December 6/2012. [s. 221. (1) 1.]

2. b) skin and wound care.
Through interviews with front line staff and the Education Coordinator it was determined all direct care staff have not received training in skin and wound care as follows:
- 46/160 (28.75%) of the staff who provide direct care received the training in 2011, and
- 59/140 (42%) of the staff who provide direct care received the training in 2012 up to December 6, 2012. [s. 221. (1) 2.]

3. c) continence care and bowel management
Through interviews with front line staff and the Education Coordinator it was determined that not all all staff who provide direct care to residents received the training in continence care as follows:
- 9/160 (5.63%) of the staff who provide direct care received the training in 2011, and
- 74/140 (52%)of the staff who provide direct care received the training in 2012 up to December 6, 2012. [s. 221. (1) 3.]

4. d) staff who apply physical devices or who monitor residents restrained by a physical device
Through interviews with front line staff and the Education Coordinator it was determined that not all all staff who provide direct care to residents received the training as follows:
- 64/160 (40%) of the staff who provide direct care received the training in 2011, and
- 82/140 (57%)of the staff who provide direct care received the training in 2012 up to December 6, 2012.
The above information was confirmed by the Education Coordinator. [s. 221. (1) 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 LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that staff received training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities. [s. 76. (2) 4.]

2. The licensee failed to ensure that all staff receive training in the area of whistle-blowing protections afforded under section 26, prior to performing their responsibilities as confirmed during record reviews and staff interviews.
This information was confirmed by the Education Coordinator, and Director of LTC Operations. [s. 76. (2) 5.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges

The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:

1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,

i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and

ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.

2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.

3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.

4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.

5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.

6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.

7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.

8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The licensee failed to provide specific goods that the licensee is required to provide to the residents using funding that the licensee receives from the Minister under section 90 of the Act.
The home's continence assessments for 3 identified residents indicated pull-ups to be used to meet residents' continence care needs. The incontinent products recommended are not being provided by the licensee. Family are purchasing them to meet residents' assessed needs. [s. 245. 1.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for residents sets out clear directions to staff and others who provide direct care to the resident in relation to the type of incontinence product to be used.
Clarification in relation to size and colour of the incontinence products was provided by the DNPC: small is white, medium is referred as regular size and mauve, large is blue, and extra large is yellow/beige in colour.
Confusion was noted when staff were interviewed about size, colour and type of the incontinence briefs. Staff confirmed that the care plan, the kardex and the brief list are documents used to provide direction related to resident care. The findings 1, 8, 9, 11, 12, 13 and 14 relate to incontinence care.

The written plan of care for resident #00004 provide conflicting information for direct care staff as follows
The care plan indicates resident wears pull ups provided by the family for days and the licensee provides briefs for nights, while the kardex indicates resident wears RB (regular briefs/purple) for days, evenings and nights.
Resident wears pull ups for days and briefs for nights. [s. 6. (1)]

2. The written plan of care for resident #41942 provides conflicting information for direct care staff and others who provide direct care to the resident in relation to assistance required for transfers.
Registered staff confirmed the resident requires supervision and occasional minimal assistance, while the written plan of care indicates conflicting directions in relation to level of assistance i.e. "resident requires extensive assistance" and "resident requires limited assistance". [s. 6. (1) (c)]

3. The written plan of care for resident #41985 provides conflicting information for direct care staff and others who provide direct care to the resident regarding oral care. The plan identifies oral care as a problem, but there are no specific interventions identified regarding frequency and the type of oral care required. [s. 6. (1) (c)]

4. The written plan of care for resident #42085 provides conflicting information for direct care staff and others who provide direct care to the resident related to fall prevention strategies.
A review of the written plan of care and the kardex for resident #42085, who is at risk for falls, identified conflicting information.
The written plan of care directs staff to attach a seat alarm while resident in the chair

- care plan indicates the resident requires extensive assistance for bathing related to unsteady gait and generalized weakness, while the bath record indicates minimum assistance for bathing; staff interview revealed the resident requires minimum assistance with bathing
- care plan indicates the resident prefers showers, Tuesday day shift and Saturday evening shift; the unit's bath assignments indicates for resident T/S (Tub or Shower) as type of bath on Tuesday day shift and Saturday evening shift.

10. The written plan of care for resident #00023 provides conflicting information for direct care staff as follows:
- the care plan indicates resident wears large briefs
- the brief list indicates resident wears extra large briefs
- continence assessment indicates resident wears adult incontinent briefs, no size specified.
Resident wears large briefs.

11. The written plan of care for resident #00022 provides conflicting information for direct care staff as follows:
- the care plan indicates resident wears medium briefs
- the kardex indicates the resident wears briefs 2 times per day but did not indicate the size to be applied
- the brief list indicates resident wears regular briefs
- continence assessment indicates resident wears incontinent briefs, no size or type specified
Resident wears medium briefs. [s. 6. (1) (c)]

12. The written plan of care for resident #00021 provides conflicting information for direct care staff as follows:
- the care plan indicates resident wears medium sized briefs
- the brief list indicates resident wears regular briefs
- continence assessment indicates the resident wears adult briefs, no size indicated
- the kardex does not indicates the resident wears incontinence briefs
Resident wears medium size briefs. [s. 6. (1) (c)]

13. The written plan of care for resident #00020 provides conflicting information for direct care staff as follows:
- the care plan indicates resident wears "regular brief(between medium and large)"

to prevent falls, while the kardex does not indicate the resident is to have a seat alarm attached when up in chair.

5. The written plan of care for resident #00003 provides conflicting information for direct care staff and others who provide direct care to the resident related to assistance for dressing.
The written plan of care indicates under interventions for dressing conflicting information: "needs 2 staff for dressing" and "provide total assist by one staff". Staff interviewed and confirmed that the resident requires assistance by one staff, and the written plan of care does not provide clear direction to the direct care staff and others. [s. 6. (1) (c)]

6. The written plan of care for resident #41903 provides conflicting information for direct care staff related to the use of bilateral half side rails for transfer purposes.
Inspector observed resident in bed with both side rails up. Resident interviewed and confirmed the need for side rails when transferring from/to the bed.
On December 3/2012 RPN confirmed that the resident did not have bed side rails identified on the plan of care as per assessment completed on November 23/2012. [s. 6. (1) (c)]

7. The written plan of care for resident #00001 provides conflicting information for direct care staff.
The identified resident is incontinent and requires toileting. Resident's written plan of care identifies that resident requires two different incontinent products, medium pull ups and medium briefs. Resident requires medium pull ups as confirmed by staff. [s. 6. (1) (c)]

8. The written plan of care for resident #42052 does not sets out clear directions to staff and others who provide direct care to the resident in relation to the type of incontinence product to be used.
The continence assessment for resident indicates requirement for pull ups. Pull ups are not indicated in the resident's written plan of care. The written plan of care states that the resident wears pads/briefs, no size specified. [s. 6. (1) (c)]

9. The licensee failed to ensure that the written plan of care for resident #00006 sets out clear directions to staff and others who provide direct care to the resident in relation to assistance needed for bathing and the type of bath/shower required;

- the brief list indicates resident wears regular briefs
- the continence assessment indicates resident wears adult briefs, no size indicated
- the kardex does not indicate the resident wears incontinence briefs
Resident wears large blue briefs. [s. 6. (1) (c)]

14. The licensee failed to ensure that the resident #00001's SDM (Substitute Decision Maker),was given an opportunity to participate fully in the development and implementation of the resident's plan of care.
Resident's SDM did not have an opportunity to participate in resident's development and implementation of plan of care in relation to the change in type of incontinent products. During December/2011 the licensee decided to remove pull-ups as an option for residents requiring this type of incontinent care product. [s. 6. (5)]

15. The licensee failed to ensure the care set out in the plan of care for resident #41922 is provided to the resident as specified in the plan.
On November 28/2012 at 8:28 resident was observed sleeping in the bed. Bed sensor was lying on bedside table and was not attached to the resident, and the call bell was not pinned to gown while resident was asleep in bed, as per plan of care.
On November 27/2012 at 09:05 resident was observed sleeping in bed without the floor mattress in place, as per plan of care. [s. 6. (7)]

16. The care set out in the plan of care is not provided to the resident #42085 as specified in the plan of care related to fall prevention strategies.
The written plan of care for the resident directs staff to attach a sensor alarm to the resident while up in the chair.
On November 28/2012 at 11:30 the resident was observed sitting in lounge on Cedar Grove in wheelchair with no clip on alarm in place.
During an interview with the RPN it was confirmed the resident should have the sensor alarm in place.
The RPN searched for the sensor alarm but it was unable to be located. [s. 6. (7)]

17. The licensee failed to ensure that the care set out in the plan of care is provided to resident #41985 as specified in the plan.
Over the course of the inspection, resident was observed to be in the lounge area without any structured activities provided.
The inspector observed the resident was not taken to a planned activity hymn sing on December 4/2012.

The attendance records indicate that resident is not participating in a minimum of 3-5 activities each week during the month of November/2012 and the week of December 2/2012 as per plan of care and confirmed by the Activation staff. [s. 6. (7)]

18. The licensee failed to ensure that the care set out in the plan of care is provided to resident #00004 as specified in the plan.
The care plan indicates for resident to be toileted before, after meals and at bed time, and to wear pull ups for days and regular briefs for nights.
During the day shift on December 4/2012, the resident was not toileted as confirmed by the record review and PSW assigned and the resident was wearing regular briefs covered by a pull up from 7:30 until 18:30; information was confirmed by the resident's wife and assigned staff. [s. 6. (7)]

19. The licensee failed to ensure that the care set out in the plan of care is provided to resident #00024 as specified in the plan.
The plan of care indicates resident wears large briefs.
Resident was observed on December 12/2012 at 8:18 to be wearing a mauve medium brief instead of the assessed need for a blue large brief.
PSW confirmed the resident did not have the correct incontinent brief in place. [s. 6. (7)]

20. The licensee failed to ensure that the care set out in the plan of care is provided to resident #00022 as specified in the plan.
- the plan of care indicates the resident is to wear a mauve medium brief
- during an interview with staff on December 11,2012 it was confirmed that the PSW applied a yellow brief to the resident when provided morning care; the PSW indicated that a yellow/beige brief was applied because it was the same color of brief the staff changed from the night shift. [s. 6. (7)]

Additional Required Actions:

CO # - 004, 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that the resident #00001's SDM is given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that resident's #00002 right to be treated with courtesy and respect in a way that fully recognizes the resident's individuality and respects resident's dignity was respected and promoted in an identified situation. The assigned PSW was observed by an external health care professional to provide personal care to the resident in a rushed manner without communicating the care to be provided. The licensee conducted an investigation and imposed disciplinary action. [s. 3. (1) 1.]

2. The licensee failed to ensure that residents right to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004, is kept confidential.
An identified registered staff was observed on Buttonville to provide report to the physician while standing in the hallway next to the residents dining area. The inspector, residents, family members and visitors in the vicinity and passing by were able to hear personal information pertaining to other residents (hospitalization, catheter issues, health status, medication, etc.). [s. 3. (1) 11. iv.]

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 by ensuring that every resident is treated with courtesy and respect in a way that fully recognizes the residents individuality and respects residents' dignity, and residents' right to have their personal health information within the meaning of the Personal Health Information Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary, as follows:
a) On November 23, 2012 at 12:24 the following were observed in an identified room:
- wheelchair foot supports soiled with feces/beverage supplement
- carpet soiled with feces/beverage supplement [s. 15. (2) (a)]

2. b) On December 4/2012, on Box Grove unit, heavily soiled carpet on left side of the bed in multiple instances from November 20 until December 4, 2012 in an identified room, were observed.
c) Chairs in all dining rooms except Union Mills observed soiled in numerous instances.
d) On December 05/2012 at 14:27 a soiled wheelchair observed in front of an identified room. [s. 15. (2) (a)]

3. e) On November 20/2012 at 10:50 the following were observed on Cedar Grove unit:
- black stains on lower wall covering outside staff washroom
- black stains on lower wall on both sides of hallway
- carpet stains outside an identified room
- carpet stains outside an identified room
- black stains on lower wall between 2 identified rooms
- white stains on carpet outside an identified room
- brown stains on carpet in the hallway between 2 identified rooms
- soiled carpet in lounge area.

On November 20/2012 at 11:15, on Victoria Square unit, black stains on lower wall in hallway between 2 identified rooms were observed.

On November 20/2012 at 11:35, on Union Mills unit white stains on carpet between 2 identified rooms were observed.

Concerns shared with Environmental Services Manager. [s. 15. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.
On December 4/2012 at approximately 10:30, the call bell in the bathroom of resident #41985 was observed to be wrapped around the grab bar and not accessible for use by resident, staff and visitors. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that the call bells can be easily accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that appropriate action was taken in response to an alleged incident of abuse of resident #00002 by a staff.
In the case of an identified critical incident, the staff who allegedly rough handled a resident while providing care was counseled by the unit manager to not raise voice and be polite at all times. No other measures were implemented. [s. 23. (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 by ensuring that appropriate action is taken in response to every incident of alleged, suspected or witnessed incident of abuse or neglect of a resident by licensee, staff or anyone, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The Director of LTC Operations failed to report immediately to the Director the alleged abuse of resident #00002 by staff that resulted in risk of harm. She was informed on an identified date about the incident but she did not inform the Director until 10 days later. [s. 24. (1)]

2. An identified Nurse Manager failed to report immediately to the Director an alleged sexual assault of resident #00005 when the staff became aware of it on the morning of an identified date. The incident was reported to the Director 24 hours later. [s. 24. (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 by ensuring that any person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk for harm is immediately reporting to the Director, to be implemented voluntarily.

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that a registered dietitian who is a member of the staff of the home completed a nutritional assessment for resident #41903 when resident was re-admitted from the hospital and a subsequent significant change in resident's hydration status occurred.
Resident records and staff interviews indicate that resident #41903 was not assessed by the registered dietitian upon return from the hospital and after the resident's health condition changed as indicated on RAPs.
Resident records and staff interviews indicate that resident was not assessed by the registered dietitian for poor intake and inadequate fluid intake until 2 months later. [s. 26. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that a registered dietitian who is a member of the staff of the home completes a nutritional assessment for all residents on admission and whenever there is a significant change in residents' health condition, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home is bathed, at minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. Staff interviews and documentation review indicate the following residents were not bathed, at minimum, twice a week.
a) Resident #00006 did not receive 2 showers/baths per week as required during 4 identified weeks from 2011 (October 31- November 6, November 14 to 20, December 5 to 11 and December 12 to 18).
b) Resident #41942 did not receive 2 baths per week as required during 6 identified weeks from 2012 (October 31 to November 6, November 7 to 13, November 14 to 20, November 21 to 27, December 5 to 11. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that each resident of the home is bathed, at minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) 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. 53 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that behavioural triggers were identified in the written approaches to care for resident #000031 demonstrating responsive behaviours. Resident's responsive behaviours will escalate when resident is soiled/incontinent, having dentures removed and when resident is exposed to a noisy environment, but these triggers were not included in the resident's written approaches to care. [s. 53. (1) 1.]

2. The licensee failed to ensure that the following behavioural trigger was identified in the written approaches to care for resident #00032 demonstrating responsive behaviours. Resident will respond in an aggressive manner when approached by other residents who will attempt to interact with the resident. [s. 53. (1) 1.]

3. The licensee failed to ensure that a written record is kept relating to each evaluation under clause (b) and 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.
Staff interviewed was unable to provide a written record during the inspection. [s. 53. (3) (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 behavioral triggers are identified for any resident in the home with responsive behaviors, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)

(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The licensee failed to ensure that the package of information for residents include:
- the long-term care home's mission statement [s. 78. (2) (b)]

2. - an explanation of the duty under section 24 to make mandatory reports related to incidents resulting in harm or risk of harm to a resident, such as:
- improper or incompetent treatment or care of a resident
- abuse by anyone or neglect by the licensee or staff
- unlawful conduct
- misuse or misappropriation of a resident's money
- misuse or misappropriation of funding provided to the licensee. [s. 78. (2) (d)]

3. - notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained [s. 78. (2) (g)]

4. - information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package [s. 78. (2) (o)]

5. - information about the Family Council, including any information that may be provided by the Family Council for inclusion in the package, and [s. 78. (2) (p)]

6. - an explanation of whistle-blowing protections afforded by section 26, of the LTCHA, related to retaliation.
Previous non compliance identified. [s. 78. (2) (q)]

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 by ensuring that the package of information for residents include:
- an explanation of whistle-blowing protections afforded by section 26, of the LTCHA, related to retaliation
- information about the Family Council, including any information that may be provided by the Family Council for inclusion in the package
- information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package
- notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained
- an explanation of the duty under section 24 to make mandatory reports related to incidents resulting in harm or risk of harm to a resident, such as:
- improper or incompetent treatment or care of a resident
- abuse by anyone or neglect by the licensee or staff
- unlawful conduct
- misuse or misappropriation of a resident's money
- misuse or misappropriation of funding provided to the licensee
- the long-term care home's mission statement, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the following information was posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements established by the regulations;
- the Residents' Bill of Rights posted in the home is communicated in French [s. 79. (3) (a)]

2. - notification on the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained [s. 79. (3) (g)]

3. - an explanation of whistle-blowing protections afforded by section 26, of the LTCHA, related to retaliation. [s. 79. (3) (p)]

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 by ensuring that the following information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements established by the regulations;
- notification on the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained,
- an explanation of whistle-blowing protections afforded by section 26, of the LTCHA, related to retaliation and
the Residents' Bill of Rights posted in the home is communicated in French, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions;
- to assist and support residents who have been abused or neglected or allegedly abused or neglected. [s. 96. (a)]

2. - to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate. [s. 96. (b)]

3. - measures and strategies to prevent abuse and neglect. [s. 96. (c)]

4. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies;
- the training and retraining requirements for all staff including:
i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
ii. situations that may lead to abuse and neglect and how to avoid such situations. [s. 96. (e)]

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 by ensuring that the home's written policy under section 20 of the Act, to promote zero tolerance of abuse and neglect of residents, is complied with according to the Regulations as follows;
- training and retraining requirements for all staff including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations
- measures and strategies to prevent abuse and neglect
- procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate
procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected, and that at least once in every calendar year, an evaluation of the policy is made to determine its effectiveness, to be implemented voluntarily.

WN #16: 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 failed to ensure that the written complaint procedures in place incorporate the requirements set out in section 101(2) and (3) of the O.Reg.79/10 for dealing with complaints as follows:
- the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and follow-up action required
- every date on which any response was provided to the complainant and the description of the response
- any response made in turn by the complainant
- the documented record is reviewed and analyzed for trends at least quarterly
- the results of the review and analysis are taken into account in determining what improvements are required in the home
- a written record is kept of each review and of the improvements made in response.
Information was confirmed by the Director of LTC Operations. [s. 100.]

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 by ensuring that the licensee's written complaint procedure in place incorporate the requirements set out in section 101(2) and (3) of the O.Reg.79/10 for dealing with complaints as follows:
- the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and follow-up action required
- every date on which any response was provided to the complainant and the description of the response
- any response made in turn by the complainant
- the documented record is reviewed and analyzed for trends at least quarterly
- the results of the review and analysis are taken into account in determining what improvements are required in the home
- a written record is kept of each review and of the improvements made in response, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented.
A review of the Restraint Monitoring Records for the following residents failed to identify required documentation as set out in the LTCHA and Regulations.
Restraint Monitoring Record for Resident #41926 for the period of November 21 to December 3/2012 did not indicate the release of the physical device and all repositioning.
Restraint Monitoring Record for Resident #42001 for the period of September 9 to September 22/2012 did not indicate the type of restraint in use or the release of the physical device and all repositioning. During this period the resident was restrained by a seat belt.
Restraint Monitoring Record for Resident #42019 for the period of November 22 to December 4/2012 did not indicate the type of restraint in use or the release of the physical device and all repositioning. Resident is currently being restrained by a seat belt.
Interviews with DNPC and registered staff confirmed the documentation was not completed as required for these residents being restrained by a physical device. [s. 110. (7) 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 by ensuring that every use of a physical device to restrain a resident under section 31 of the Act is documented for every release of the device and repositioning, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in a medication area that is used exclusively for drugs and drug related supplies.
On November 21/2012 medication fridges in the medication rooms were observed and the following were noted;
- 6 boxes (946 ml) of Resource, 1 bottle of Soda tonic, 15 sealed apple sauce containers, 1 open jar of jam were stored in the medication fridge on Box Grove, and
- 6 containers of Glucerna, 2 sealed apple sauce containers, 1 sealed yogurt were stored in the medication fridge on Buttonville. [s. 129. (1) (a) (i)]

2. The licensee failed to ensure that drugs are stored in a medication cart that is secure and locked as noted in the following occurrences;
- On December 10/2012 at 15:45 the inspector observed an open oblong plastic tray labeled Group 1 with several bottles of prescription topical medications on top of the care cart sitting outside room #243 on Cedar Grove. There was no staff in attendance. [s. 129. (1) (a) (ii)]

3. - On December 12/2012 at 8:19 the inspector observed an open oblong plastic tray labeled Group 1 with several prescription topical medications sitting on top of the care cart in the hallway outside resident room #246 on Cedar Grove. There was no staff in attendance. [s. 129. (1) (a) (ii)]

4. - On November 27/2012 at 11;46, on Buttonville unit, the medication cart was observed open in the hallway; the registered staff was in a resident room administering medication. [s. 129. (1) (a) (ii)]

5. - On November 26/2012 at 07:50 the medication cart was observed to be unlocked, parked in the lounge across from the nurses' station, on Cedar Grove. There were no staff observed in the area. There was a cognitively impaired resident sitting in the lounge beside the cart. [s. 129. (1) (a) (ii)]

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 by ensuring that all prescription creams, topical medications and any other medications are stored in an area or a medication cart that is secured and locked and that is used exclusively for drugs and drug related supplies, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The registered nursing staff permit staff members who are not otherwise permitted to administer a drug to a resident to administer a topical when the staff has not been trained by a member of the registered staff in the administration of topical.
Interviews with several PSWs indicated they apply topical ointments and creams by following the written directions on the label. PSWs confirmed they have not received training regarding the application of the topical ointments/creams. [s. 131. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that unregulated staff who administer topicals
- has been trained by a member of the registered nursing staff in the administration of topicals
- the registered nursing staff who is permitting the administration is satisfied that the unregulated staff member can safely administer the topical, and
- the unregulated staff who administer the topical does so under the supervision of the member of the registered nursing staff, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure the staff participate in the infection prevention and control program.
a) On November 27/2012 at 11:48, on Buttonville, an identified registered staff came out of a resident room holding a Nitrogen patch without gloves. The staff did not practice hand hygiene after disposing the patch.
b) On November 27/2012, on Cedar Grove, outside an identified room used gloves were observed on top of the display case on the right side of the door. [s. 229. (4)]

2. - During the administration of medication pass on November 26/2012 at 08:00 on Cedar Grove the registered staff was observed not to practice hand hygiene between residents who were administered oral medications, insulin injections and glucometer readings. [s. 229. (4)]

3. The licensee failed to ensure the staff participate in the infection prevention and control program.
- During the tour of the 2nd floor on Cedar Grove unit on November 20, 2012 at 10:50 soiled towels and incontinent briefs were observed on the floor of the Cedar Grove spa. [s. 229. (4)]

4. The licensee failed to ensure that each resident admitted to the home was screened for tuberculosis (TB) within 14 days of admission or resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee, as follows:
- Resident #0007 was not screened for TB
- Resident #41942 was screened incompletely for TB: first step was negative,but second step was not performed or documented
- Resident # 41945 was not screened for TB
Information was confirmed by registered staff and DNPC. [s. 229. (10) 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 by ensuring the following:
- that all staff participate in the implementation of the infection prevention and control program, and
- each resident admitted to the home has been screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee, to be implemented voluntarily.

WN #21: 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 staff complied with the home's policy TB (tuberculosis) screening- TB testing/recording employees/students/agency/volunteers/contracted services- last reviewed on May 1/2009.
The policy indicates for staff that the proof of TB screening should be recent and after clarifying with the DNPC it was confirmed that TB screening should be not older than 6 months.
An identified staff had on file at the time of hiring a TB test completed 12 months before the starting date. [s. 8. (1)]

2. The licensee failed to ensure that staff complied with the home's policy Inventory Control- Drug Disposal, no. 02-06-20 from July 1/2010. The policy indicates that the following medications will be identified, destroyed and disposed: expired medications, medications with illegible labels, medications that are not labeled appropriately as per labeling standards and medications that are no longer required due to being discontinued, or when a resident is discharged or deceased.
On November 27/2012 the medication cupboard on Box Grove was observed and the following were identified:
- Docusate sodium bottle expiration date July/2012,and
- medication pouches for Coumadin failed to identify expiration dates for three identified residents
On November 27/2012 at 11:50 the medication cupboard on Buttonville was observed and the following medications were identified as expired:
- NovoMix 30 Penfill- expired on October/2012,
- 2 vials of Pmeumovax vaccine- expired on December 16/2011.
- Calamine lotion- expired on February/2012. [s. 8. (1)]

3. The licensee failed to ensure that staff complied with the home's policy – Topical Medications RCS F-70 dated June 4, 2012 which indicates personal support workers will be trained to administer topical medications (cream or ointment)to the resident. The training will include observation of the personal support worker applying the topical cream or ointments to the resident(s) on three separate occasions and record on the home's independent administration record that the training was provided.
During an interview, a RPN indicated the training provided for PSWs consists of verbal direction. The RPN was not aware of any requirement to complete any documentation.
PSWs have not received training regarding the application of the topical

ointments/creams as per home's policy and confirmed through staff interviews.
The home was unable to provide documentation on an independent administration documentation record to indicate PSWs had been trained and observed 3 separate times during the application of topicals.
DNPC confirmed the policy was currently not in place. [s. 8. (1) (b)]

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that resident #00004 is not neglected by an identified staff of the home on an identified occasion.
The resident was observed to wear a regular brief covered by a pull up for containment, and the resident was not toileted for 11 continuous hours.
The licensee conducted an investigation of the incident and measures were put in place to prevent re-occurrence. [s. 19. (1)]

2. The licensee failed to protect resident #00008 from verbal and emotional abuse by an identified staff of the home on an identified occasion. An identified PSW made an inappropriate comment and spoke in a loud voice using an intimidating manner when resident requested assistance.
The licensee conducted an investigation of the incident and measures were put in place to prevent re-occurrence. [s. 19. (1)]

WN #23: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with by identified staff on two identified occasions as follows;
- resident #00008 was not protected from verbal and emotional abuse by an identified staff of the home on an identified occasion, and
- resident #00004 was not protected from neglect of staff in the home on an identified occasion. [s. 20. (1)]

2. The licensee failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 of the Act to make mandatory reports. [s. 20. (2)]

WN #24: 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 written description of the home's responsive behaviour program includes the following:
- goals and objectives
- relevant policies, procedures, protocols
- methods to reduce risk
- methods to monitor outcomes, and
- protocols for referral of resident to specialized resources where required. [s. 30. (1) 1.]

2. The licensee failed to ensure that the home's rehabilitation and restorative care program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. It was confirmed by the rehabilitation and restorative care coordinator that an annual evaluation is not being completed. [s. 30. (1) 3.]

WN #25: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee did not ensure that there is a restraint plan of care in place for resident #41985 who is being restrained by a physical device, bilateral 3/4 side rails.
Interviews with staff confirmed the use of the side rails is to keep the resident in bed as a fall prevention strategy. [s. 31. (1)]

2. The restraint plan of care resident #41985 does not include an order by the physician or the registered nurse in the extended class.
The plan of care for resident who is at risk for falls directs staff to put 2 side rails up at all times when in bed for safety. The side rails were observed to be 3/4 in length.
Interviews with direct care staff and RPN confirmed the resident is able to move about in bed and the purpose of the side rails is to keep the resident in the bed. [s. 31. (2) 4.]

WN #26: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days to the Family Council after receiving any concerns and recommendations from the Council concerning the operations of the home.
The home's President and CEO confirmed that the licensee did not respond in writing within 10 days of receiving Family Council advice of concerns or recommendations on September/2012 minutes related to the quantity of food, small plates, urinary tract infections, residents need for more water, and suggested change in toilet paper. These same concerns were noted as requiring follow up in the October/2012 minutes. [s. 60. (2)]

WN #27: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 86. Accommodation services programs

Specifically failed to comply with the following:

s. 86. (2) Where services under any of the programs are provided by a service provider who is not an employee of the licensee, the licensee shall ensure that there is in place a written agreement with the service provider that sets out the service expectations. O. Reg. 79/10, s. 86 (2).

s. 86. (3) The licensee shall ensure that there are written policies and procedures to monitor and supervise persons who provide occasional maintenance or repair services to the home pursuant to the agreement referred to in subsection (2). O. Reg. 79/10, s. 86 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that there are in place written agreements with the service providers, who are not the employees of the licensee, that set out the service expectations.
The licensee was not able to provide written agreements for companies who provide services for emergency generators, security monitoring, odor control, plumbing and grease traps maintenance. This information was confirmed by the Environmental Services Manager during the interview. [s. 86. (2)]

2. The licensee failed to ensure that there are written policies and procedures to monitor and supervise persons who provide occasional maintenance or repair services to the home pursuant to the written agreement referred to in subsection(2)of O. Reg. 79/10. This information was confirmed by the Environmental Services Manager during the interview. [s. 86. (3)]

WN #29: 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 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. Information was confirmed by the home's Director of the Long Term Home Operations. [s. 99. (b)]

WN #30: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that 5 identified reports to the Director included the following description of the incident:
- area or location of the incident. [s. 104. (1) 1.]

2. The licensee failed to ensure that 1 identified report to the Director, included the following description of the individuals involved in the incident:
- names of any staff members or other persons who were present at or discovered the incident. [s. 104. (1) 2.]

3. The licensee failed to ensure that 1 identified report to the Director, included the following actions taken in response to the incident:
- whether a family member, person of importance or SDM of any resident(s) involved in the incident was contacted and the name of such person or persons
- the outcome or current status of the individual or individuals who were involved in the incident, resident's current status. [s. 104. (1) 3.]

WN #31: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure there was a documented reassessment of each resident's drug regime at least quarterly for resident #00017.
The quarterly medication review for the period May 1 to July 31/2012 was completed by the physician on May 24/2012, and for the period August 1 to October 31, 2012 was completed by the physician on September 12, 2012.
It was confirmed during interview with DNPC that resident's documented reassessment should have been completed at least quarterly. [s. 134. (c)]

WN #32: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the resident's health.
During a review of medications for resident #00018 it was noted a physician order written on May 7/2011 for a change of laxative from Milk of Magnesia to Lactulose 30cc daily did not get transcribed to the electronic medication administration record.
Interview with Pharmacist confirmed this was a transcription error and a medication incident will be completed by the pharmacy.
The home was unaware of this transcription error until informed by the inspector during the inspection. [s. 135. (1)]

WN #33: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
1. The resident's ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1). O. Reg. 79/10, s. 224 (1).

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
8. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the package of information provided on admission includes information on the resident's ability to retain a physician or a registered nurse in the extended class to perform the required services. [s. 224. (1) 1.]

2. The licensee failed to ensure that the package of information provided on admission includes information on the Ministry's toll-free telephone number for making complaints about the home and its hours of service. [s. 224. (1) 8.]

Issued on this 28th day of January, 2013

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MONICA NOURI (193), LYNN PARSONS (153), TIINA TRALMAN (162)
Inspection No. / No de l'inspection :	2012_103193_0012
Log No. / Registre no:	T-2116-12
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 23, 2013
Licensee / Titulaire de permis :	UNIONVILLE HOME SOCIETY 4300 Highway #7, MARKHAM, ON, L3R-1L8
LTC Home / Foyer de SLD :	UNION VILLA 4300 Highway #7, Unionville, ON, L3R-1L8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DEBRA COOPER-BURGER

To UNIONVILLE HOME SOCIETY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan outlining how the following required training will be provided to all staff who provide direct care to residents; falls prevention and management, skin and wound care, continence care and bowel management, training for staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices, training for staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs.
The plan must be submitted by February 7/2013.

Grounds / Motifs :

1. The licensee failed to provide training to all staff who provide direct care to residents as follows:
a) falls prevention and management
Through interviews with front line staff and the Education Coordinator it was determined that not all staff who provide direct care to residents received the

training for falls prevention and management as follows:
- 54/160 (33%) of the staff who provide direct care received the training in 2011, and
- 83/140 (59%) of the staff who provide direct care received the training up to December 6/2012.
(153)

2. b) skin and wound care.
Through interviews with front line staff and the Education Coordinator it was determined all direct care staff have not received training in skin and wound care as follows:
- 46/160 (28.75%) of the staff who provide direct care received the training in 2011, and
- 59/140 (42%) of the staff who provide direct care received the training in 2012 up to December 6, 2012. (153)

3. c) continence care and bowel management
Through interviews with front line staff and the Education Coordinator it was determined that not all staff who provide direct care to residents received the training in continence care as follows:
- 9/160 (5.63%) of the staff who provide direct care received the training in 2011, and
- 74/140 (52%)of the staff who provide direct care received the training in 2012 up to December 6, 2012. (153)

4. d) staff who apply physical devices or who monitor residents restrained by a physical device
Through interviews with front line staff and the Education Coordinator it was determined that not all staff who provide direct care to residents received the training as follows:
- 64/160 (40%) of the staff who provide direct care received the training in 2011, and
- 82/140 (57%)of the staff who provide direct care received the training in 2012 up to December 6, 2012.
The above information was confirmed by the Education Coordinator. (153)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 03, 2013

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee must ensure that all direct care staff have received training in the areas mentioned below prior to performing their responsibilities:

1. The duty under section 24 to make mandatory reports, and
2. The protections afforded by section 26.

Grounds / Motifs :

1. The licensee failed to ensure that staff received training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities, as confirmed during record reviews and staff interviews.

(193)

2. The licensee failed to ensure that all staff receive training in the area of whistle-blowing protections afforded under section 26, prior to performing their responsibilities as confirmed during record reviews and staff interviews.

The above information was confirmed by the Education Coordinator, and the Director of LTC Operations. (193)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 01, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 245. The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act.
O. Reg. 79/10, s. 245.

Order / Ordre :

The licensee must provide pull up incontinence products to all residents with an assessed need for this specific incontinence product at no charge to the resident.

Grounds / Motifs :

1. The licensee failed to provide specific goods that the licensee is required to provide to the residents using funding that the licensee receives from the Minister under section 90 of the Act.
The home's continence assessments for identified residents indicated pull-ups to be used to meet residents' continence care needs. The incontinent products recommended are not being provided by the licensee. Family are purchasing them to meet residents' assessed needs. (193)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 22, 2013

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan outlining the process to ensure that all documents considered by the licensee to be part of a residents' written plan of care provide clear direction to staff and others who provide care for residents related to activities of daily living and fall prevention strategies for 14 identified residents.
The licensee must submit the plan by February 7/2013.

Grounds / Motifs :

1. The licensee failed to ensure that the written plan of care for resident #00006 sets out clear directions to staff and others who provide direct care to the resident in relation to assistance needed for bathing and the type of bath/shower required;
- care plan indicates the resident requires extensive assistance for bathing related to unsteady gait and generalized weakness, while the bath record indicates minimum assistance for bathing; staff interview revealed the resident requires minimum assistance with bathing
- care plan indicates the resident prefers showers, Tuesday day shift and Saturday evening shift; the unit's bath assignments indicates for resident T/S (Tub or Shower) as type of bath on Tuesday day shift and Saturday evening shift. (193)

2. The licensee failed to ensure that the written plan of care for residents sets out clear directions to staff and others who provide direct care to the resident in

relation to the type of incontinence product to be used.
Clarification in relation to size and colour of the incontinence products was provided by the DNPC: small is white, medium is referred as regular size and mauve, large is blue, and extra large is yellow/beige in colour.
Confusion was noted when staff were interviewed about size, colour and type of the incontinence briefs. Staff confirmed that the care plan, the kardex and the brief list are documents used to provide direction related to resident care.

The written plan of care for resident #00004 provides conflicting information for direct care staff as follows
The care plan indicates resident wears pull ups provided by the family for days and the licensee provides briefs for nights, while the kardex indicates resident wears RB (regular briefs/purple) for days, evenings and nights.
Resident wears pull ups for days and briefs for nights. (193)

3. The written plan of care for resident #00020 provides conflicting information for direct care staff as follows:
- the care plan indicates resident wears "regular brief(between medium and large)"
- the brief list indicates resident wears regular briefs
- the continence assessment indicates resident wears adult briefs, no size indicated
- the kardex does not indicate the resident wears incontinence briefs
Resident wears large blue briefs. (153)

4. The written plan of care for resident #00021 provides conflicting information for direct care staff as follows:
- the care plan indicates resident wears medium sized briefs
- the brief list indicates resident wears regular briefs
- continence assessment indicates the resident wears adult briefs, no size indicated
- the kardex does not indicates the resident wears incontinence briefs
Resident wears medium size briefs. (153)

5. The written plan of care for resident #00022 provides conflicting information for direct care staff as follows:
- the care plan indicates resident wears medium briefs
- the kardex indicates the resident wears briefs 2 times per day but did not

indicate the size to be applied
- the brief list indicates resident wears regular briefs
- continence assessment indicates resident wears incontinent briefs, no size or type specified
Resident wears medium briefs. (153)

6. The written plan of care for resident #00023 provides conflicting information for direct care staff as follows:
- the care plan indicates resident wears large briefs
- the brief list indicates resident wears extra large briefs
- continence assessment indicates resident wears adult incontinent briefs, no size specified.
Resident wears large briefs. (153)

7. The written plan of care for resident #42052 does not sets out clear directions to staff and others who provide direct care to the resident in relation to the type of incontinence product to be used.
The continence assessment for resident indicates requirement for pull ups. Pull ups are not indicated in the resident's written plan of care. The written plan of care states that the resident wears pads/briefs, no size specified.

(153)

8. The written plan of care for resident #00001 provides conflicting information for direct care staff.
The identified resident is incontinent and requires toileting. Resident's written plan of care identifies that resident requires two different incontinent products, medium pull ups and medium briefs. Resident requires medium pull ups as confirmed by staff. (193)

9. The written plan of care for resident #41903 provides conflicting information for direct care staff related to the use of bilateral half side rails for transfer purposes.
Inspector observed resident in bed with both side rails up. Resident interviewed and confirmed the need for side rails when transferring from/to the bed.
On December 3/2012 RPN confirmed that the resident did not have bed side rails identified on the plan of care as per assessment completed on November 23/2012. (162)

10. The licensee failed to ensure that the written plan of care for resident #41953 sets out clear directions to staff and others who provide direct care to the resident related to ambulation.
Resident uses an assistive device for ambulation as per staff interviews and observation. This intervention was not indicated in the resident's plan of care. (162)

11. The written plan of care for resident #00003 provides conflicting information for direct care staff and others who provide direct care to the resident related to assistance for dressing.
The written plan of care dated April 19/2012 indicates under interventions for dressing conflicting information: "needs 2 staff for dressing" and "provide total assist by one staff". Staff interviewed and confirmed that the resident requires assistance by one staff, and the written plan of care does not provide clear direction to the direct care staff and others. (193)

12. The written plan of care for resident #42085 provides conflicting information for direct care staff and others who provide direct care to the resident related to fall prevention strategies.
A review of the written plan of care and the kardex for the resident, who is at risk for falls, identified conflicting information.
The written plan of care updated October 26/2012 directs staff to attach a seat alarm while resident in the chair to prevent falls, while the kardex does not indicate the resident is to have a seat alarm attached when up in chair.

Previous history of non compliance with LTCHA s. 6(1)(c). (153)

13. The written plan of care for resident #41985 provides conflicting information for direct care staff and others who provide direct care to the resident regarding oral care.
The plan identifies oral care as a problem, but there are no specific interventions identified regarding frequency and the type of oral care required. (193)

14. The written plan of care for resident #41942 provides conflicting information for direct care staff and others who provide direct care to the resident in relation to assistance required for transfers.
Registered staff confirmed the resident requires supervision and occasional

minimal assistance, while the written plan of care dated August 3/2012 indicates conflicting directions in relation to level of assistance i.e. "resident requires extensive assistance" and "resident requires limited assistance". (193)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 01, 2013

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must ensure that the care set out in the plan of care related to recreation and social activities, continence and bowel management, and fall prevention strategies, is provided as specified in the plan to six identified residents.

Grounds / Motifs :

1. The licensee failed to ensure that the care set out in the plan of care is provided to resident #00022 as specified in the plan.
The plan of care indicates the resident is to wear a mauve medium brief.
During an interview with staff on December 11,2012 it was confirmed that the PSW applied a yellow brief to the resident when provided morning care; the PSW indicated that a yellow/beige brief was applied because it was the same colour of brief the staff changed from the night shift. (153)

2. The licensee failed to ensure that the care set out in the plan of care is provided to resident #00024 as specified in the plan.
The plan of care indicates resident wears large briefs.
Resident was observed on December 12/2012 at 8:18 to be wearing a mauve medium brief instead of the assessed need for a blue large brief.
PSW confirmed the resident did not have the correct incontinent brief in place and this resulted in brief cutting into resident's skin, leaving red marks and increased in risk of skin breakdown. (153)

3. The licensee failed to ensure that the care set out in the plan of care is provided to resident #00004 as specified in the plan;
The care plan indicates for resident to be toileted before, after meals and at bed

time, and to wear pull ups for days and regular briefs for nights.
During the day shift on December 4/2012, the resident was not toileted as confirmed by the record review and PSW assigned, and the resident was wearing regular briefs covered by a pull up from 7:30 until 18:30; information was confirmed by the resident's wife and assigned staff. (193)

4. The licensee failed to ensure that the care set out in the plan of care is provided to resident #41985 as specified in the plan.
Over the course of the inspection, resident was observed to be in the lounge area without any structured activities provided.
Inspector observed the resident was not taken to a planned activity hymn sing on December 4/2012.
The attendance records indicate that resident is not participating in a minimum of 3-5 activities each week during the month of November/2012 and the week of December 2/2012 as per plan of care and confirmed by the Activation staff. (162)

5. The care set out in the plan of care is not provided to the resident #42085 as specified in the plan of care related to fall prevention strategies.
The written plan of care for the resident directs staff to attach a sensor alarm to the resident while up in the chair.
On November 28/2012 at 11:30 the resident was observed sitting in lounge on Cedar Grove in wheelchair with no clip on alarm in place.
During an interview with the RPN it was confirmed the resident should have the sensor alarm in place.
The RPN searched for the sensor alarm but it was unable to be located. (153)

6. The licensee failed to ensure the care set out in the plan of care for resident #41922 is provided to the resident as specified in the plan.
On November 28/2012 at 8:28 the resident was observed sleeping in the bed. The bed sensor was lying on bedside table and was not attached to the resident, and the call bell was not pinned to gown while resident was asleep in bed, as per plan of care.
On November 27/2012 at 09:05 resident was observed sleeping in bed without the floor mattress in place, as per plan of care.

Previous history of non compliance with LTCHA s. 6(7).
(153)

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 01, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 23rd day of January, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : MONICA NOURI

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