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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 23, 2017	2017_595604_0015	022464-17	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

THE WILLOWS ESTATE NURSING HOME
13837 YONGE STREET AURORA ON L4G 3G8

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

SHIHANA RUMZI (604), DEREGE GEDA (645)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 26, 27, 28, October 2, 3, 4, 5, 6, and 10, 2017.

During the course of the inspection, the following Critical Incident System (CIS) report intakes were inspected:
-Log # 002332-17 - related to missing resident with injury.

During the course of the inspection, the following Complaint Intakes were inspected:
-Log #032672-16 – Complaint related to alleged improper care and physical abuse from staff to resident.
-Log #002361-17 – Complaint related to abuse and neglect of residents.
-Log #021045-17 – Complaint related to improper care of residents and misappropriation of resident food.
-Log #021698-17 – Complaint related to emotional abuse by staff, neglect and improper care, missed medication doses, and continence care concerns.
-Log #012633-17 – Complaint related to alleged resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Charge Registered Nurse (CRN), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Dietary Aid (DA), Cook, Maintenance, Resident Care Coordinator (RCC), Nutritional Care Manager (NCM), Housekeepers, Residents, and Family Members.

During the course of the inspection, the inspectors conducted a tour of the home, made observations of tray services, lunch meal observation, medication administration, staff and resident interactions, provision of care, conducted reviews of health records, and critical incident and complaint logs, staff training records, reviewed meeting minutes of Residents' Council meetings, and reviewed relevant home's policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Sufficient Staffing

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

- **10 WN(s)**
- **3 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that the planned menu items were offered at each meal.

The Ministry of Health and Long-Term Care (MOHLTC) ACTIONline received a

complaint on an identified date from resident #003. The resident indicated he/she had chewing challenges and the food served in the home is unbelievable and was receiving poor quality food.

An interview conducted with resident #003 indicated he/she has communicated his/her concerns with the home's Nutritional Care Manager (NCM) #115 and things are getting better. The resident indicated he/she has his/her meals in an identified area of the home but receives poor quality food for his/her supper meal which is also undistinguishable as he/she does not know what he/she is getting for his/her meals.

The inspector conducted a tray service observation on an identified date and time. The two meal choices for the supper meal was as follows:
1) Chalet Chicken, home fries, mixed vegetables, and brownie,
2) Veal Pizzaolio, egg noodles, wax beans, and half a banana,

The tray cart for an identified floor for the supper meal was brought out of the kitchen into the hall at 1640 hrs, and Personal Support Worker (PSW) #113 wheeled the cart down to the identified floor and started to deliver the trays according to the names on the "Dietary Tray Service Requisition". The inspector observed the "Dietary Tray Service Requisition", consisted of residents name only.

The following residents received trays on an identified date and floor, for their supper meal:
-Resident #003 - Received a regular diet, minced texture meal consisting of minced chicken, mash potato with gravy, minced vegetables, and brownie,
-Resident #004 - Received a regular diet, regular texture meal consisting of chalet chicken, home fries with gravy, wax beans, and brownie,
-Resident #006 - Received a regular diet, regular texture meal consisting of veal with red sauce, noodles, wax beans, and a brownie,
-Resident #007 - Received a regular diet, regular texture meal consisting of chalet chicken, mixed vegetables, wax beans, and home fries,
-Resident #009 - Received a regular diet, regular texture meal consisting of mixed vegetables (carrot, broccoli, and cauliflower), home fries, and wax beans,
-Resident #011 - Received a regular diet, regular texture meal consisting of minced chicken, mashed potato with gravy, minced mixed vegetables, and a brownie,

Interviews were conducted with resident #003, #004, #006, #007, and #009, individually as they received their meal trays. Resident #011 was not interviewable due to cognitive

impairment and language barrier. The residents each acknowledged that he/she was not asked or informed of the two meal choices for the supper meal service and are unable to recall a time where they were ever given a choice of meals if they were on tray service. The residents stated they don't know what they were going to have for the supper meal till they are provided with their tray and they eat what they are provided with for the supper meal.

The inspector observed resident #009 having his/her meal on an identified unit. The resident received his/her tray which was a regular diet, regular texture supper meal consisting of mixed vegetables (carrot, broccoli, and cauliflower), home fries, and wax beans.

An interview with resident #009 indicated he/she is unsure of what he/she received for his/her supper meal. The tray was delivered by PSW #113 who observed what resident #009 received on his/her tray for his/her meal.

The inspector was provided with resident #009's "Week 3 Regular Menu at a Glance", which indicated the resident requested mashed potatoes, peas or carrots, cheddar cheese, egg noodles, and half a banana as the resident is a vegetarian.

An interview with the NCM #115 indicated resident #009 receives the three week menu for the month and the NCM and the resident completes the menu together as to the resident's preference for each meal. The NCM stated the meal chosen by resident #009 for the identified date at the supper meal according to the "Week 3 Regular Menu At a Glance", was mashed potatoes, peas or carrots, cheddar cheese, egg noodles, and half a banana.

The NCM indicated the kitchen staff are to refer to the "Week 3 Regular Menu At a Glance", for the resident when making the tray. The NCM indicated resident #009 did not receive the meal that he/she had chosen to have for his/her supper meal.

The inspector visited an identified floor and PSW #114 indicated he/she had eight residents on tray service for an identified meal and provided the inspector with the list of residents. Residents #012, #013, #,14, #015, #016, #017, and #018, where observed and had completed their meal.

The inspector attempted to interview residents on an identified floor and the residents were unable to be interviewed and unable to inform the inspector of the meal they had

due to their level of cognitive impairment.

An interview conducted with PSW #113 who confirmed he/she delivered the meal trays to the residents on an identified floor and Registered Nurse (RN) #118 completed the "Dietary Tray Service Requisition", form for the supper meal and delivered it to the kitchen. The PSW indicated there were eight trays for the identified floor for the supper meal and he/she was unaware of what meal each resident would receive till the tray was delivered. The PSW stated there are two meal choices for supper and stated six out of the eight residents are competent and are able to make a meal choice if given the option. The PSW acknowledged he/she did not offer the residents on tray service a meal choice and he/she is unsure as to whose responsibility it was to communicate the meal choices to the residents on tray service. The PSW stated he/she has observed the kitchen staff on occasion come to the floor and offer the choices but it was not a consistent practice. The PSW further stated if the residents where to attend supper meal service in the large dining room they would get two meal choices.

An interview conducted with PSW #116 indicated on an identified floor he/she had eight residents on tray service for supper and the Registered Practical Nurse (RPN) #117 completed the "Dietary Tray Service Requisition" and then took it down to the kitchen. The PSW indicated he/she was unable to recall what meal each resident received for their supper tray and stated that he/she did not ask or offer the two choices for the supper meal and indicated residents on the identified floor can't choose a meal if asked. The PSW further stated he/she is unsure if the kitchen staff are to come up to the floor to communicate the two meal choices.

Interviews conducted with RPN #117 and RN #118 on two identified floors confirmed the home provides two meal choices for the supper meal and they completed the "Dietary Tray Service Requisition" form for their assigned floors for the supper meal. The RN and RPN confirmed that they delivered the forms to the kitchen and did not offer 15 residents on tray service the two meal options available for supper. The RN and RPN indicated that residents who attend meal services in the main dining room where offered the two meal options available for the supper meal.

An interview with Cook #102 confirmed that on two identified floors the RN and RPN brought down the "Dietary Tray Service Requisition", for to the kitchen for the supper meal and the form only indicates the resident's name. The Cook stated the residents on tray service are given a meal according to their diet e.g. if the resident is a regular diet and regular texture the resident gets a regular meal but is not offered the two choices of

meal unless the residents come to the main dining room. The Cook acknowledged that he/she did not go to the floors to offer the two meal choices as there is no direction as to who is to carry out that function.

An interview with the Dietary Aid (DA) #101 indicated there is always two choices for the supper meal service in the main dining room but if the residents are on tray service they are given any meal according to their diet in the plan of care.

An interview with the home's Nutritional Care Manager (NCM) #115 indicated the home provides two choices of meals for supper. The NCM stated one person from the kitchen, the Cook or the DA is to go up to the floors with the show plates and ask the resident on tray service which meal they would like for supper. If the residents do not like either choices for supper then a sandwich or toast is offered to the resident. The NCM acknowledged that for the identified date at the supper meal 15 residents where not offered the two planned menu items for their supper meal.

The home is being served an order as the severity of the non-compliance and the severity of harm and risk is potential as residents #003, #004, #006, #007, #009, #011, #012, #013, #14, #015, #016, #017, and #018, where not offered the planned menu items available for their supper meal. A review of resident #009's "Week 3 Regular Menu at a Glance", indicated the resident requested mashed potatoes, peas or carrots, cheddar cheese, egg noodles, and half a banana for his/her supper on an identified date, which was not provided to the resident as chosen by the resident.

The scope of the non-compliance is widespread.

A review of the home's compliance history revealed that there has been previous non-compliances issued related to the Long-Term Care Homes Act O. Reg. 79/10, s. 71 (4), which is as follows:
- Resident Quality Inspection, conducted on August 17, 2015, inspection #2015_168202_0013 – WN.

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

Findings/Faits saillants :

The licensee has failed to ensure that the home was a safe and secure environment for its residents.

The home submitted a CIS report, to the MOHLTC on an identified date, indicating missing resident with injury. The CIS report stated resident #002 was last seen at 0545hrs, by the night staff prior to the end of their shift and then at 0730hrs, when a day shift staff member entered resident #002's room he/she observed the window on the floor and the resident was unable to be located. Code yellow was called and the police were notified when resident #002 was not found in the home. The resident was found at 0810hrs, at the rear of the home in his/her pajamas with one shoe missing. Resident #002 was returned to the home and was assessed and later transferred to hospital for further assessment. Resident #002 was returned to the home.

A review of resident #002's electronic progress notes on Mede-Care, indicated the resident had been admitted to the home on an identified date. Further review of the progress notes showed no evidence of the identified responsive behaviour and the Community Care Access Centres (CCAC) assessments did not identify the responsive behaviour.

A review of resident #002's written plan of care prior to the identified responsive behaviour did not contain a "Problem(s)", related to this identified responsive behaviour.

A review of the plan of care following the identified responsive behaviour indicated specific interventions in place to manage the identified responsive behaviour. The interventions implemented were in place to identify the location of the resident to the staff at all times.

An interview with resident #002 stated he/she was unable to recall the date or time of the incident but recalls a desire to leave the long-term care home and to return to in his/her own home and be surrounded by his/her family.

During the course of the inspection the inspector carried out multiple observations. During this time the inspector conducted interviews related to observations:
On an identified date and time:
-Resident #002 was lying in bed and the inspector observed as he/she entered the room the blinds where pulled back and the window to be open and the window was not equipped with a window screen.
-The window consisted of a latch to ensure the window could not open past 15 cm, a sensor alarm mounted to the left side of the wall next to the window which was observed to be in the "Off" position pointing away from the window.

An interview and observation was carried out with RN #110 who acknowledged that resident #002's window did not have a window screen and the sensor alarm was in the "Off" position. The RN indicated that the window not having a window screen was a safety risk to resident #002 due to the incident which occurred in January 2017. The RN indicated he/she would get the Environmental/Maintenance Service Manager (EMSM) to address the missing window screen.

The Administrator arrived as the EMSM was unavailable and acknowledged resident #002's window was missing the screen and the sensor alarm was in the "Off" position which was attached to the wall next to the window. The Administrator further indicated that the resident had an identified responsive behaviour earlier this year and indicated the window not having a screen posed a safety risk to resident #002.

On an identified date and time,
-The inspector observed a "Monitor Check Room" to be on a clipboard outside of resident #002's room to be not completed. The check indicated it is to be completed by the registered staff at the start of the shift. The inspector kept monitoring the check sheet till 1345hrs, when the inspector went to carry out another room observation for resident #002 the "Monitor Check Room" check sheet was still not completed at 1340hrs, till it was brought to RPN #112's attention.

On an identified date and time,
-As the inspector entered resident #002's room the window was observed to be fully opened and the window sensor alarm was observed to be in the "Off" position pointing away from the window. Further observations revealed the window was equipped with a window latch to prevent the window from opening past 15cm.

An interview with Registered Practical Nurse (RPN) #112 indicated he/she was an agency staff from Staff Relief but has been coming to the home for the past three years. The RPN indicated he/she received report on an identified date, from the night staff related to resident #002. The RPN acknowledged that he/she did not check resident #002's room to complete the "Monitor Check Room" for the identified room.

An interview and observation was conducted with Administrator on an identified date. The Administrator acknowledged the window in resident #002's room was fully open and the window sensor alarm was in the "Off" position. The inspector showed the Administrator the "Monitor Check Room" sheet and the Administrator reviewed the "Monitor Check Room" sheet. The Administrator stated the "Monitor Check Room" check sheet is to be completed by registered staff at the beginning of their shift to check the room to ensure the window sensor and bed alarm was functioning to ensure the safety of resident #002 and acknowledged that the "Monitor Check Room", form was not completed for the identified date and shift.

Interviews with PSW #107 and #113 indicated they were resident #002's primary PSWs. The PSWs indicated the resident presented with an identified responsive behaviour early this year and identified interventions where implemented to ensure the safety of resident #002. The PSWs indicated he/she did not notice the above observations related to the missing window screen, the window being fully open, and the window sensor alarm to be in the "Off" position when he/she provided morning care to resident #002. The PSWs further stated they did not check the window or the window alarm during their shift as it was not a part of their safety checks.

Further interviews were conducted with the Administrator who confirmed the above interventions were put into place to ensure resident #002 was safe in the home after the resident presented with an identified responsive behaviour on an identified date. The Administrator acknowledged RPN #112 did not ensure the interventions put in place were being completed and monitored to provide resident #002 with a safe and secure environment.

The home is being served an order as the severity of the non-compliance and the severity of harm and risk is actual as resident #002 presented with an identified responsive behaviour on an identified date, between the hours of 0545 – 0730hrs, through an identified area of the home and was found at 0810hrs, in the rear of the home in the forest area. The home put in place safety interventions. The interventions put in place by the home to ensure the safety of resident #002 was not implemented whereby

resident #002 was not provided a safe and secure environment.

The scope of the non-compliance is isolated.

A review of the home's compliance history revealed that the home has not had previous non-compliances issued related to the Long-Term Care Homes Act 2007, c. 8, s. 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 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).

Findings/Faits saillants :

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

The home submitted a CIS report, to the MOHLTC on an identified date, indicating missing resident with injury. The CIS report stated resident #002 was last seen at 0545hrs, by the night staff prior to the end of their shift and then at 0730hrs, when a day shift staff member entered resident #002's room he/she observed the window on the floor and the resident was unable to be located. Code yellow was called and the police were notified when resident #002 was not found in the home. The resident was found at 0810hrs, at the rear of the home in his/her pajamas with one shoe missing. Resident #002 was returned to the home and was assessed and later transferred to hospital for further assessment. Resident #002 was returned to the home.

A review of resident #002's written plan of care prior to his/her identified responsive behaviour with-in two identified review periods did not contain a "Problem(s)", related to identified responsive behaviors as the resident did not present with these responsive behaviours in the past.

A review of the plan of care following the identified responsive behaviour confirmed by the home to be currently in effect with an identified date, indicate under the first "Problem (s)", the identified responsive behaviour and interventions indicated redirect when presenting with the responsive behaviour at night related to an identified health diagnosis is to assist to toilet, give snacks, every 15 minute security checks, sensor alarm installed on the bed and window area to alert staff when the resident gets out of bed or presents with the identified responsive behaviour. The second "Problem(s)", statement safety devices/restraints impaired mobility, related to an identified responsive behaviour. The intervention indicated the bed alarm and the window alarm to alert staff when the resident attempts to get up of his/her own or attempts to open window. The inspector did not see the "Monitor Check Room", sheet for the identified room included as an intervention for resident #002.

During the course of the inspection the inspector carried out multiple observations. During this time the inspector conducted interview related to observations:
On an identified date and time,
-The inspector observed a "Monitor Check Room", for an identified room to be on a clipboard outside of resident #002's room to be not completed. The room check indicated it is to be completed by the registered staff at the start of the shift. The inspector kept monitoring the check sheet till 1345hrs, when the inspector went to carry out another room observation for resident #002 the "Monitor Check Room", check sheet was still not completed at 1340hrs, till it was brought to RPN #112's attention.

An interview with Registered Practical Nurse (RPN) #112 indicated he/she was an agency staff from Staff Relief but has been coming to the home for the past three years. The RPN indicated he/she received report on an identified date, from the night staff related to resident #002 on the first floor. The RPN acknowledged that he/she did not check resident #002's room to complete the "Monitor Check Room ", and stated the room check was not on the written plan of care so he/she was unaware that he/she has to carryout "Monitor Check Room", and unaware it was a part of his/her duties on the day shift.

Interviews with PSW #107 and #113 indicated they were resident #002's primary PSWs. The PSWs indicated the resident presented with an identified responsive behaviour early this year and identified interventions where implemented to ensure the safety of resident #002. The PSW's acknowledged that there was a "Monitor Check Room", sheet outside resident #002's room. The PSW's reviewed the current written plan of care and stated that the plan of care didn't have the "Monitor Check Room", sheet as an intervention and didn't know whose duty it was to carry out the checks.

An interview conducted with the DOC indicated the written plan of care is to consist of information staff need to provide care to the resident and also safety measures in place if the resident has responsive behaviours or is exit seeking. The DOC stated resident #002 presented with an identified responsive behaviour early this year and has safety measures in place which includes a "Monitor Check Room", posted outside his/her room and it was to be carried out by the day nurse on the unit at the beginning of his/her shift. The DOC was provided with a copy of the written plan of care following the resident's responsive behaviour as confirmed by the home to be currently in effect with a identified print date. The DOC reviewed the written plan of care with the inspector and acknowledged he/she put the "Monitor Check Room", sheet in place as another step to ensure safety for resident #002 and the DOC further acknowledged that the written plan of care did not consist the "Monitor Check Room", sheet as an intervention. The DOC stated as the "Monitor Check Room", sheet was not included in the written plan of care and staff didn't have clear direction as to who is to carry out the "Monitor Check Room", sheet and when the check is to be done.

The home is being served an order as the severity of the non-compliance and the severity of harm and risk is actual as resident #002 presented with an identified responsive behaviour on an identified date, between the hours of 0545 - 0730hrs, and was found at 0810 hrs, in the rear of the home in the forest area. The home put in place safety interventions which also included a "Monitor Check Room" sheet which was to be carried out at the beginning of the shift by the unit nurse on the first floor. The intervention put in place by the home to ensure the safety of resident #002 was not included in the written plan of care where by no clear direction was provided to staff and resident #002 was not provided a safe and secure environment.

The scope of the non-compliance is isolated.

A review of the home's compliance history revealed that the home has had previous noncompliance's issued related to the Long-Term Care Homes Act 2007, c. 8, s. 6 (1):

- Resident Quality Inspection, 2016_414110_0010, September 30, 2016 – VPC
- Resident Quality Inspection, 2015_168202_0013, August 17, 2015 – VPC
- Resident Quality Inspection, 2014_168202_0027, November 28, 2014 – VPC

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 O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents had a screen.

The home submitted a CIS report, to the MOHLTC on an identified date, indicating missing resident with injury. The CIS report stated resident #002 was last seen at 0545hrs, by the night staff prior to the end of their shift and then at 0730hrs, when a day shift staff member entered resident #002's room he/she observed the window on the floor and the resident was unable to be located. Code yellow was called and the police were notified when resident #002 was not found in the home. The resident was found at 0810hrs, at the rear of the home in his/her pajamas with one shoe missing. Resident #002 was returned to the home and was assessed and later transferred to hospital for further assessment. Resident #002 was returned to the home.

During a room observation conducted on an identified date and time, the inspector observed the room window to be open with a latch which limited the window opening more than 15 centimetres (cm) and observed the window did not consist of a window screen.

An interview with RN #110 indicated he/she was unsure if the resident's window in his/her room was to consist of a window screen. The RN observed resident's room

window and confirmed the window did not contain a window screen. The RN indicated resident #002 had presented with an identified responsive behaviour early this year. The RN indicated he/she would get the Environmental Services Manager for the building. The RN carried out an overhead page and after five minutes arrived and indicated that the manager did not arrive or call the unit. The RN got the Administrator who arrived at 1315hrs.

An interview with the Administrator indicated all the windows in home that open to the outdoor and are accessible to residents should have a screen in place. The Administrator observed resident #002's room window and confirmed the window did not have a window screen. The Administrator indicated it was a risk as resident #002 presented with identified responsive behaviours and the window not having a window screen posed a safety risk for the resident.

2. The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents cannot be opened more than 15 centimetres.

The home submitted a CIS report, to the MOHLTC on an identified date, indicating missing resident with injury. The CIS report stated resident #002 was last seen at 0545 hrs, by the night staff prior to the end of their shift and then at 0730 hrs, when a day shift staff member entered resident #002's room he/she observed the window on the floor and the resident was unable to be located. Code yellow was called and the police were notified when resident #002 was not found in the home. The resident was found at 0810 hrs, at the rear of the home in his/her pajamas with one shoe missing. Resident #002 was returned to the home and was assessed and later transferred to hospital for further assessment. Resident #002 was returned to the home along with a prescription.

During a room observation conducted on an identified date and time, the inspector observed the room window to be open with a latch which limited the window opening more than 15 centimetres (cm).

Observations where conducted on an identified floor of the windows by the inspector and RN #110. All windows consisted of a latch which prevented the windows from opening greater than 15cm.

An interview and observation was conducted with the Administrator acknowledged the window in resident #002's room was opened greater than 15 cm. The Administrator

indicated the window being opened fully posed an risk to the resident as he/she had presented with an identified responsive behaviour earlier this year.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that every window in the home:
-opens to the outdoors and is accessible to residents and had a screen,
-cannot be opened more than 15 centimetres,, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area that was secure and locked.

The inspector conducted an initial tour of the home on an identified date. During the course of the tour on an identified floor the inspector observed an identified door in the home to be open at 1110hrs, and observed an identified prescription with resident #052's name to be in the room.

An interview with Charge Registered Nurse (CRN) #119 indicated medicated/prescribed medications should be safely stored in the secure medication room located by the nursing station. The CRN acknowledged the identified prescription for resident #052 was not stored in a secure area and was stored in an identified area of the home utilised by residents and visitors thus providing them access to the prescribed medications.

On an identified date and time, the inspector observed an identified medication to be stored at the bedside table in an identified room. The medication was labelled as belonging to resident #055.

An interview with RPN#130 indicated the expectation of the home was that prescribed medications are to be stored in the locked medication room. The RPN acknowledged resident #055's prescribed medication was not stored securely.

An interview with the Director of Care (DOC) stated it was the home's expectation that all topical medications be safely stored in the locked medication room. The DOC indicated the above observation made by the inspector of the medications posed a risk as it gave residents and visitors access to prescribed medications.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that drugs were stored in an area that was secure and locked,, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The MOHLTC ACTIONline received a complaint on an identified date. The complainant indicated during meal times residents are not given the time to finish their meal and staff in the home rush the residents out of the dining room.

The inspector conducted a lunch meal observation on an identified date, in the main dining room. During the lunch meal observation the inspector observed the following:

1) At 1235 hrs, Dietary Aid (DA) #100 throwing a napkin in-to a black garbage bin by lifting the black lid on the garbage bin and then proceeded to the servery table and pick up resident #002's main lunch meal.

2) At 1245 hrs, resident #020 was sitting at table #9 eating his/her ice cream sandwich. The resident had the sandwich in the wrapper and placed the ice cream down on the table, DA #101 arrived with a cart and a green bucket and started to place a green cloth in the bucket, wring it out and started to wipe the table #9 down. The DA then lifted resident #020's cup of apple juice and water to clean under the table under the cups and then pick up the ice cream sandwich sitting on the table and hand it to the resident with his/her wet hands.

3) At 1255 hrs, the inspector observed the DA #100 loading dirty dishes on to the dirty dish racks and loading it into the dishwasher and then pull out the clean dish rack with clean dishes to the right and proceeded to unload the clean dishes from the dish rack onto a metal cart with the same hands he/she handled the dirty dishes.

An interview conducted with DA #100, indicated the staff are expected to wash their

hands when going from dirty to clean. The DA acknowledged that he/she did touch the lid of the garbage then pick up the lunch meal plate for resident #002 and he/she did not perform hand hygiene in between when he/she went from dirty to clean.

An interview conducted with DA #101 stated the staff are expected to wash their hands when going from dirty to clean for sanitary reasons. The DA indicated he/she had detergent and hot water in the green bucket and was wiping the tables off after lunch. The DA indicated the direction of the home is that they do not wipe tables when a resident is still seated at the table having his/her meals. The DA indicated that he/she should not have touch resident #020's drinks or ice cream as it was cross contamination.

A follow up interview with DA #100 was carried out and he/she confirmed that he/she went from dirty to clean dishes and did not wash his/her hands in between. The Cook #102 and DA/Cook #103 was in the servery and indicated that the staff do the same on all shift and there is only one staff to do the dirty and clean dishes after each meal.

The Nutritional Care Manager #115 was away from the home and the Administrator was informed of the above three observations.

An interview with the Administrator indicated the kitchen staff are expected to wash their hands if they are handling dirty dishes and handling clean dishes as it is infection control issue. The Administrator indicated that he/she was unaware that the current DA staff practices involved going from clean to dirty dishes and the DA #100 demonstrated to the administrator how he/she carried out cleaning the dishes. The Administrator indicated that it was cross contamination when DA #100 was loading dirty dishes on to the dirty dish racks and then taking the clean dishes out of the dishwasher with the same dirty hands and loading them on the clean cart. The Administrator indicated the Nutritional Care Manager was off and acknowledged the kitchen staff where not following proper infection control practices.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that staff participated in the implementation of the infection prevention and control program,, to be implemented voluntarily.

WN #7: 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).

Findings/Faits saillants :

1. The home's written policy "Zero Tolerance of Abuse" policy #AM-6-9, with a revision date of June 2016, directed staff that if any alleged, suspected or witnessed abuse, staff are to notify the administration team immediately.

The licensee has failed to ensure that the home's written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

The MOHLTC INFOLINE received two complaints related to alleged incidents of abuse pertaining to resident #011 and #051 from anonymous sources. The initial complaint was received on an identified date, involving resident #051, and the second anonymous complaint was received on an identified date pertaining to resident #011.

An interview with the Complainant #131 confirmed that he/she observed PSW#121 being rough with resident #051 on an identified date an shift. The complainant further stated resident #051 pushed PSW#121 away and stated you are hurting me and refused the care. The complainant indicated he/she reported the incident he/she witnessed immediately to Charge RN# 122 the same day.
Inspector was unable to verify the alleged incident as indicated above from the

anonymous source involving resident #011.

An interview conducted with Charge RN (CRN) #122 stated it was the expectation of the home to report any alleged, suspected or witnessed abuse to the management team immediately in order for the home to start their investigation and report it to the MOHLTC. The CRN revealed that the allegation of abuse involving resident #051 was reported to him/her and he/she immediately responded by assessing the resident and he/she did not find any injuries at that time. The RN confirmed that he/she did not report the alleged abuse to the management team. The CRN indicated that he/she does not recall why he/she did not report the allegation of abuse to the management team and stated he/she should have reported the incident to the management team.

An interview with the DOC indicated all staff in the home where trained and are expected to report any alleged abuse immediately to the administration team in order for the home to start an investigation and report to the MOHLTC. The DOC stated all registered staff are expected to notify the administrator during regular business hours and manager on call afterhours and acknowledged that it is the role of the manager on duty or on call to conduct the investigation and to notify the MOHLTC. The DOC stated he/she was unaware of the incident as indicated above and the witnessed alleged abuse involving PSW #121 and resident #051 was not reported to the management team by the staff members in the home.

WN #8: 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, s. 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, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 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, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who has reasonable grounds to suspect that any alleged misuse of funding provided to the licensee under this Act or the Local Health System Integration Act, 2006, was immediately reported to the Director.

The MOHLTC ACTIONline received a Complaint, on an identified date. An interview was carried out on an identified date, by the Centralized Intake Assessment and Triage Team (CIATT) with the complainant. The complainant at this time indicated to the CIATT that during meal time, especially on Mondays when bacon and eggs are served, staff remove resident's food prior to offering of the meals to residents and put the food aside for themselves to eat at a later time.

An interview with Complainant #128, indicated he/she verbally notified the Administrator and DOC that staff members in the home were eating residents' food during dining services which occurs predominantly on the weekends. The complainant stated that he/she indicated to the management that he/she observed staff members eating residents' food on several occasions. Complainant #128 indicated he/she went to the Administrators office and verbally reported the allegation both to the administrator and DOC however was unable to recall the date but indicated it was during an identified time in 2017.

The inspector reviewed the "home's Complaints Binder 2016/2017", and did not find

documentation related to the above allegation.

Inspector #604 carried out breakfast observation on an identified date and time and carried out observations till the end of the breakfast meal at 0921hrs. The two meal choices for the breakfast meal was as follows:
1) Assorted juices, hot oatmeal, scrambled eggs, assorted fruited, toast and breakfast turkey patty
2) Peanut butter, fresh fruit, carrot loaf and assorted cold cereal.
During the course of the breakfast observation inspector #604 visited the servery and did not observe any food placed a-side or the breakfast meal run short of the breakfast items.

Interviews conducted with the home's DOC and Administrator indicated a verbal complaint from PSW #128 was brought to them related to the concern indicated above, the DOC and Administrator stated they were unable to recall the date the verbal complaint was brought to their attention. During the interview, the DOC stated that he/she conducted an investigation following the above complaint and indicated that the outcome of the investigation did not substantiate the allegation of misuse of funding provided to the licensee as the DOC did not witness staff taking resident food prior to offering to the residents and then ingesting themselves the food taken. The DOC confirmed that the MOHLTC Director was not notified of the alleged incident and stated that the alleged misuse of funding should have been immediately reported to the MOHLTC Director.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that that each resident who was incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bladder continence based on their assessment and that the plan was implemented.

The MOHLTC ACTIONline received a complaint on an identified date, related to resident #052.The complaint stated on an identified date, PSW #123 applied two incontinent products to resident #052.

A record review of resident #052's written plan of care with an identified effective date, under the "Problem(s)" statement Bladder Incontinence included an intervention that staff were to use disposable incontinent products and to change the resident frequently due to identified health concerns. The written plan of care also stated resident #052 required frequent changes of his/her incontinent product.

An interview with Complainant #131 indicated resident #052 had two incontinent products in place at the beginning of his/her identified shift on an identified date. Complainant #131 stated, PSW #123 had applied two incontinent briefs to resident #052 on an identified shift. Complainant #131 stated this practice was unacceptable as per home expectation and the written plan of care for resident #052 did not direct staff to apply two incontinent products on the resident.

An interview with PSW#123 indicated he/she applied two continence products to resident #052 once or twice over a year ago and stated that he/she does not utilize that practice anymore as the home provided him/her with training related to continence care and the requirement to provide care to the residents as per their plans of care.

An interview with the DOC revealed it is not acceptable practice to apply two incontinent products to residents in the home and staff are expected to follow the residents' plan of care.

The DOC stated resident #52's plan of care did not direct staff to apply two incontinent products. The DOC further stated, staff received training on the requirement to follow the written plan of care, along with reminder memos sent on regular basis.

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every written complaint made to the licensee concerning the care of a resident was investigated and resolved where possible, and response provided within 10 business days of receipt of the complaint.

The home's CRN #119, received a complaint letter through email on an identified date, from resident #004's Substitute Decision Maker (SDM) #120. The email indicated resident #004 was being tormented by his/her roommate resident #005 and the roommate in the next room assaulted resident #004 in the past. In the email the complaint indicated the Willow Estates was responsible for any further assaults or torment of resident #004 and the home is to provide a secure and homely environment

for its senior residents and he/she will expect a reply in a timely manner. The home sent the email complaint through the mail to the MOHLTC which was received by the MOHLTC Central Intake and Triage Team (CIATT) on an identified date.

An interview with SDM #120 indicated resident #004 was currently in a new room and is satisfied. The complainant further stated he/she sent an email to the home's CRN #119 and the DOC and did not receive a verbal or written reply till a month later, from the DOC. The SDM stated after he/she had sent the initial email on an identified date, he/she called and spoke to the CRN #119 and was asked to resend the email. The complainant stated he/she had to wait for a month before he/she had a reply and was dissatisfied.

The inspector reviewed the complainant's email with an identified date sent to CRN #119 and the DOC. The inspector observed that the CRN #119's email address was correct and the DOC's email was incorrect and the complainant resent the email on an identified date. The inspector noted the date on the home's reply sent to the complainant. The home replied 21 days later after the home received the initial email complaint for resident #004's SDM.

An interview with the home's DOC indicated if a written complaint is received it is immediately addressed by the Administrator or DOC of the home. In the absences of the DOC the Charge RN will take on the role of Acting DOC and any complaints verbal or written is to be taken to the Administrator to address immediately. The DOC indicated he/she was aware of the complaint brought to the home through email by the SDM of resident #004 as he/she was away from the home and the CRN would be expected to responsible to any complaints.

An interview with the CRN #119 indicated if a complaint is brought to him/her he/she will try to resolve the complaint and will inform the DOC of the complaint. The CRN further stated if the DOC was away from the home the he/she was expected to take the complaint to the Administrator immediately. The CRN confirmed that the email address on the complaints email with an identified date was correct and he/she did received the email complaint from resident #004's SDM. The CRN indicated that the email went into his/her junk mail which he/she did not check. The CRN indicated SDM #120 called him/her upset and inquired why he/she had not replied to him/her related to his/her complaint letter related to treatment of resident #004. The CRN indicated as he/she did not check his/her junk email he/she was unaware of the complaint and did not take the written complaint to the home's administrator.

A further interview with the DOC confirmed that the CRN #119 did not have direction related to checking their email which included there junk mail box. The DOC indicated he/she returned from vacation on an identified date, and addressed the complaint. The DOC indicated the CRN didn't check his/her junk email box and indicated he/she was unsure why the email went into the CRN's junk mail box and the complaint was not addressed. The DOC confirmed that the complaint was not responded to with-in ten days of receiving the complaint.

2. The licensee has failed to ensure that a documented record was kept in the home which included the nature of each verbal and written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, the date on which any response was provided to the complainant and a description of the response, and any response made in turn by the complainant.

The MOHLTC ACTIONline received a complaint on an identified date. An interview was carried out on an identified date, by the Centralized Intake Assessment and Triage Team (CIATT) with the complainant. The complainant at this time indicated to the CIATT that during meal time, specially Mondays when bacon and eggs served, staff remove resident's food prior to offering the meals to residents and put the food aside for themselves to eat at a later time.

An interview with Complainant #128, indicated he/she verbally notified the Administrator and DOC that staff members in the home were eating residents' food during dining services which occurs predominantly on the weekends. The complainant stated that he/she indicated to the management that he/she observed staff members eating residents' food on several occasions. Complainant #128 indicated he/she went to the Administrators office and verbally reported the allegation both to the administrator and DOC however was unable to recall the date but indicated it was during an identified month in 2017.

The home's policy "Complaints Procedure", policy AM- 6.1, with an effective date of November 2010, under policy number six it directs staff that all details and information related to the investigation shall be recorded and documented. A record review of the home's "Complaints Binder 2016/2017" did not reveal any documentation in regards to the verbal complaints or investigation notes related to staff taking resident food prior to offering the food to the residents at meals.

Interviews conducted with the home's DOC and Administrator indicated a verbal complaint from PSW #128 was brought to them related to the concern indicated above, the DOC and Administrator stated they were unable to recall the date the verbal complaint was brought to their attention. During the interview, the DOC stated that he/she conducted an investigation following the above complaint and indicated that the outcome of the investigation did not substantiate the allegation of misuse of funding provided to the licensee as the DOC did not witness staff taking resident food prior to offering to the residents and then ingesting themselves the food taken. The DOC acknowledged he/she could not provide the inspector with evidence related to keeping a record of the complaint which included the date or time of the complaint was received, who made the complaint, the investigation notes, and resolution of the investigation.

Issued on this 24th day of November, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHIHANA RUMZI (604), DEREGE GEDA (645)
Inspection No. / No de l'inspection :	2017_595604_0015
Log No. / No de registre :	022464-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 23, 2017
Licensee / Titulaire de permis :	Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner 2020 Fisher Drive, Suite 1, PETERBOROUGH, ON, K9J-6X6
LTC Home / Foyer de SLD :	THE WILLOWS ESTATE NURSING HOME 13837 YONGE STREET, AURORA, ON, L4G-3G8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Linda Burr

To Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

Within one week of receipt of this order the licensee shall prepare, submit and implement a plan to ensure that:
1) All resident's in the home who have been identified to be on tray service will be offered and informed of the two choices of meals available to them.

2) All residents in the home who complete a Weekly Regular Menu at a Glance for each week and month must receive their choice of meals as indicated and chosen by the residents in the Weekly Regular Menu at a Glance.

3) Develop and implement a process to ensure all residents receive their choice of meals as predetermined on the Weekly Regular Menu at a Glance.

Please submit the plan to shihana.rumzi@ontario.ca. within one week of receipt of this order by November 30, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that the planned menu items were offered at each meal.

The Ministry of Health and Long-Term Care (MOHLTC) ACTIONline received a complaint on an identified date from resident #003. The resident indicated he/she had chewing challenges and the food served in the home is unbelievable and was receiving poor quality food.

An interview conducted with resident #003 indicated he/she has communicated his/her concerns with the home's Nutritional Care Manager (NCM) #115 and things are getting better. The resident indicated he/she has his/her meals in an identified area of the home but receives poor quality food for his/her supper meal

which is also undistinguishable as he/she does not know what he/she is getting for his/her meals.

The inspector conducted a tray service observation on an identified date and time. The two meal choices for the supper meal was as follows:
1) Chalet Chicken, home fries, mixed vegetables, and brownie,
2) Veal Pizzaolio, egg noodles, wax beans, and half a banana,

The tray cart for an identified floor for the supper meal was brought out of the kitchen into the hall at 1640 hrs, and Personal Support Worker (PSW) #113 wheeled the cart down to the identified floor and started to deliver the trays according to the names on the "Dietary Tray Service Requisition". The inspector observed the "Dietary Tray Service Requisition", consisted of residents name only.

The following residents received trays on an identified date and floor, for their supper meal:
-Resident #003 - Received a regular diet, minced texture meal consisting of minced chicken, mash potato with gravy, minced vegetables, and brownie,
-Resident #004 - Received a regular diet, regular texture meal consisting of chalet chicken, home fries with gravy, wax beans, and brownie,
-Resident #006 - Received a regular diet, regular texture meal consisting of veal with red sauce, noodles, wax beans, and a brownie,
-Resident #007 - Received a regular diet, regular texture meal consisting of chalet chicken, mixed vegetables, wax beans, and home fries,
-Resident #009 - Received a regular diet, regular texture meal consisting of mixed vegetables (carrot, broccoli, and cauliflower), home fries, and wax beans,
-Resident #011 - Received a regular diet, regular texture meal consisting of minced chicken, mashed potato with gravy, minced mixed vegetables, and a brownie,

Interviews were conducted with resident #003, #004, #006, #007, and #009, individually as they received their meal trays. Resident #011 was not interviewable due to cognitive impairment and language barrier. The residents each acknowledged that he/she was not asked or informed of the two meal choices for the supper meal service and are unable to recall a time where they were ever given a choice of meals if they were on tray service. The residents stated they don't know what they were going to have for the supper meal till they are provided with their tray and they eat what they are provided with for the

supper meal.

The inspector observed resident #009 having his/her meal on an identified unit. The resident received his/her tray which was a regular diet, regular texture supper meal consisting of mixed vegetables (carrot, broccoli, and cauliflower), home fries, and wax beans.

An interview with resident #009 indicated he/she is unsure of what he/she received for his/her supper meal. The tray was delivered by PSW #113 who observed what resident #009 received on his/her tray for his/her meal.

The inspector was provided with resident #009's "Week 3 Regular Menu at a Glance", which indicated the resident requested mashed potatoes, peas or carrots, cheddar cheese, egg noodles, and half a banana as the resident is a vegetarian.

An interview with the NCM #115 indicated resident #009 receives the three week menu for the month and the NCM and the resident completes the menu together as to the resident's preference for each meal. The NCM stated the meal chosen by resident #009 for the identified date at the supper meal according to the "Week 3 Regular Menu At a Glance", was mashed potatoes, peas or carrots, cheddar cheese, egg noodles, and half a banana.

The NCM indicated the kitchen staff are to refer to the "Week 3 Regular Menu At a Glance", for the resident when making the tray. The NCM indicated resident #009 did not receive the meal that he/she had chosen to have for his/her supper meal.

The inspector visited an identified floor and PSW #114 indicated he/she had eight residents on tray service for an identified meal and provided the inspector with the list of residents. Residents #012, #013, #,14, #015, #016, #017, and #018, where observed and had completed their meal.

The inspector attempted to interview residents on an identified floor and the residents were unable to be interviewed and unable to inform the inspector of the meal they had due to their level of cognitive impairment.

An interview conducted with PSW #113 who confirmed he/she delivered the meal trays to the residents on an identified floor and Registered Nurse (RN)

#118 completed the "Dietary Tray Service Requisition", form for the supper meal and delivered it to the kitchen. The PSW indicated there were eight trays for the identified floor for the supper meal and he/she was unaware of what meal each resident would receive till the tray was delivered. The PSW stated there are two meal choices for supper and stated six out of the eight residents are competent and are able to make a meal choice if given the option. The PSW acknowledged he/she did not offer the residents on tray service a meal choice and he/she is unsure as to whose responsibility it was to communicate the meal choices to the residents on tray service. The PSW stated he/she has observed the kitchen staff on occasion come to the floor and offer the choices but it was not a consistent practice. The PSW further stated if the residents where to attend supper meal service in the large dining room they would get two meal choices.

An interview conducted with PSW #116 indicated on an identified floor he/she had eight residents on tray service for supper and the Registered Practical Nurse (RPN) #117 completed the "Dietary Tray Service Requisition" and then took it down to the kitchen. The PSW indicated he/she was unable to recall what meal each resident received for their supper tray and stated that he/she did not ask or offer the two choices for the supper meal and indicated residents on the identified floor can't choose a meal if asked. The PSW further stated he/she is unsure if the kitchen staff are to come up to the floor to communicate the two meal choices.

Interviews conducted with RPN #117 and RN #118 on two identified floors confirmed the home provides two meal choices for the supper meal and they completed the "Dietary Tray Service Requisition" form for their assigned floors for the supper meal. The RN and RPN confirmed that they delivered the forms to the kitchen and did not offer 15 residents on tray service the two meal options available for supper. The RN and RPN indicated that residents who attend meal services in the main dining room where offered the two meal options available for the supper meal.

An interview with Cook #102 confirmed that on two identified floors the RN and RPN brought down the "Dietary Tray Service Requisition", for to the kitchen for the supper meal and the form only indicates the resident's name. The Cook stated the residents on tray service are given a meal according to their diet e.g. if the resident is a regular diet and regular texture the resident gets a regular meal but is not offered the two choices of meal unless the residents come to the main dining room. The Cook acknowledged that he/she did not go to the floors

to offer the two meal choices as there is no direction as to who is to carry out that function.

An interview with the Dietary Aid (DA) #101 indicated there is always two choices for the supper meal service in the main dining room but if the residents are on tray service they are given any meal according to their diet in the plan of care.

An interview with the home's Nutritional Care Manager (NCM) #115 indicated the home provides two choices of meals for supper. The NCM stated one person from the kitchen, the Cook or the DA is to go up to the floors with the show plates and ask the resident on tray service which meal they would like for supper. If the residents do not like either choices for supper then a sandwich or toast is offered to the resident. The NCM acknowledged that for the identified date at the supper meal 15 residents where not offered the two planned menu items for their supper meal.

The home is being served an order as the severity of the non-compliance and the severity of harm and risk is potential as residents #003, #004, #006, #007, #009, #011, #012, #013, #14, #015, #016, #017, and #018, where not offered the planned menu items available for their supper meal. A review of resident #009's "Week 3 Regular Menu at a Glance", indicated the resident requested mashed potatoes, peas or carrots, cheddar cheese, egg noodles, and half a banana for his/her supper on an identified date, which was not provided to the resident as chosen by the resident.

The scope of the non-compliance is widespread.

A review of the home's compliance history revealed that there has been previous non-compliances issued related to the Long-Term Care Homes Act O. Reg. 79/10, s. 71 (4), which is as follows:
- Resident Quality Inspection, conducted on August 17, 2015, inspection #2015_168202_0013 – WN.
(604)

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 : Feb 01, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

Within one week of receipt of this order the licensee shall prepare, submit and implement a plan to ensure that:

1) Resident #002 is provided with a safe and secure environment where-by:
-The resident room window has a screen in place,
-The sensor alarm mounted on resident #002's window is set to the "on" position and pointed towards the window,
-The room "Monitor Check for Room" sheet for resident #002's room contains documentation for the required time frames consistent with the resident's plan of care requirements.
-The room window is not able to be opened greater than 15cms.

2) A communication strategy is developed and implemented to ensure all staff in the home are aware of the interventions in place for resident #002 related to his/her identified responsive behaviour.

3) Develop and implement a process to audit all windows in the home that open to the outside and are accessible to residents to ensure they have a screen in place and cannot be opened greater than 15cms.

4) Develop and maintain a written record of the above auditing process which also includes measures implemented if these windows do not contain a screen and/or open greater than 15cms.

Please submit the plan to shihana.rumzi@ontario.ca. within one week of receipt of this order by November 30, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

The home submitted a CIS report, to the MOHLTC on an identified date, indicating missing resident with injury. The CIS report stated resident #002 was last seen at 0545hrs, by the night staff prior to the end of their shift and then at 0730hrs, when a day shift staff member entered resident #002's room he/she observed the window on the floor and the resident was unable to be located. Code yellow was called and the police were notified when resident #002 was not found in the home. The resident was found at 0810hrs, at the rear of the home in his/her pajamas with one shoe missing. Resident #002 was returned to the home and was assessed and later transferred to hospital for further assessment. Resident #002 was returned to the home.

A review of resident #002's electronic progress notes on Mede-Care, indicated the resident had been admitted to the home on an identified date. Further review of the progress notes showed no evidence of the identified responsive behaviour and the Community Care Access Centres (CCAC) assessments did not identify the responsive behaviour.

A review of resident #002's written plan of care prior to the identified responsive behaviour did not contain a "Problem(s)", related to this identified responsive behaviour.

A review of the plan of care following the identified responsive behaviour indicated specific interventions in place to manage the identified responsive behaviour. The interventions implemented were in place to identify the location of the resident to the staff at all times.

An interview with resident #002 stated he/she was unable to recall the date or time of the incident but recalls a desire to leave the long-term care home and to return to in his/her own home and be surrounded by his/her family.

During the course of the inspection the inspector carried out multiple observations. During this time the inspector conducted interviews related to observations:
On an identified date and time:

-Resident #002 was lying in bed and the inspector observed as he/she entered the room the blinds where pulled back and the window to be open and the window was not equipped with a window screen.
-The window consisted of a latch to ensure the window could not open past 15 cm, a sensor alarm mounted to the left side of the wall next to the window which was observed to be in the "Off" position pointing away from the window.

An interview and observation was carried out with RN #110 who acknowledged that resident #002's window did not have a window screen and the sensor alarm was in the "Off" position. The RN indicated that the window not having a window screen was a safety risk to resident #002 due to the incident which occurred in January 2017. The RN indicated he/she would get the Environmental/Maintenance Service Manager (EMSM) to address the missing window screen.

The Administrator arrived as the EMSM was unavailable and acknowledged resident #002's window was missing the screen and the sensor alarm was in the "Off" position which was attached to the wall next to the window. The Administrator further indicated that the resident had an identified responsive behaviour earlier this year and indicated the window not having a screen posed a safety risk to resident #002.

On an identified date and time,
-The inspector observed a "Monitor Check Room" to be on a clipboard outside of resident #002's room to be not completed. The check indicated it is to be completed by the registered staff at the start of the shift. The inspector kept monitoring the check sheet till 1345hrs, when the inspector went to carry out another room observation for resident #002 the "Monitor Check Room" check sheet was still not completed at 1340hrs, till it was brought to RPN #112's attention.

On an identified date and time,
-As the inspector entered resident #002's room the window was observed to be fully opened and the window sensor alarm was observed to be in the "Off" position pointing away from the window. Further observations revealed the window was equipped with a window latch to prevent the window from opening past 15cm.

An interview with Registered Practical Nurse (RPN) #112 indicated he/she was

an agency staff from Staff Relief but has been coming to the home for the past three years. The RPN indicated he/she received report on an identified date, from the night staff related to resident #002. The RPN acknowledged that he/she did not check resident #002's room to complete the "Monitor Check Room" for the identified room.

An interview and observation was conducted with Administrator on an identified date. The Administrator acknowledged the window in resident #002's room was fully open and the window sensor alarm was in the "Off" position. The inspector showed the Administrator the "Monitor Check Room" sheet and the Administrator reviewed the "Monitor Check Room" sheet. The Administrator stated the "Monitor Check Room" check sheet is to be completed by registered staff at the beginning of their shift to check the room to ensure the window sensor and bed alarm was functioning to ensure the safety of resident #002 and acknowledged that the "Monitor Check Room", form was not completed for the identified date and shift.

Interviews with PSW #107 and #113 indicated they were resident #002's primary PSWs. The PSWs indicated the resident presented with an identified responsive behaviour early this year and identified interventions where implemented to ensure the safety of resident #002. The PSWs indicated he/she did not notice the above observations related to the missing window screen, the window being fully open, and the window sensor alarm to be in the "Off" position when he/she provided morning care to resident #002. The PSWs further stated they did not check the window or the window alarm during their shift as it was not a part of their safety checks.

Further interviews were conducted with the Administrator who confirmed the above interventions were put into place to ensure resident #002 was safe in the home after the resident presented with an identified responsive behaviour on an identified date. The Administrator acknowledged RPN #112 did not ensure the interventions put in place were being completed and monitored to provide resident #002 with a safe and secure environment.

The home is being served an order as the severity of the non-compliance and the severity of harm and risk is actual as resident #002 presented with an identified responsive behaviour on an identified date, between the hours of 0545 – 0730hrs, through an identified area of the home and was found at 0810hrs, in the rear of the home in the forest area. The home put in place safety

interventions. The interventions put in place by the home to ensure the safety of resident #002 was not implemented whereby resident #002 was not provided a safe and secure environment.

The scope of the non-compliance is isolated.

A review of the home's compliance history revealed that the home has not had previous non-compliances issued related to the Long-Term Care Homes Act 2007, c. 8, s. 5.
(604)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 01, 2018

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) (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 :

Within one week of receipt of this order the licensee shall prepare, submit and implement a plan to ensure that:

1) Resident #002's plan of care is revised and reviewed to ensure interventions related to safety are addressed in-to the plan of care.

2) Develop and implement a communication strategy to ensure all staff on the unit are updated and are aware of the interventions in place to ensure the safety of resident #002.

3) Develop and implement a process to audit all resident plans of care to ensure they include all interventions necessary for the safety of each resident.

Please submit the plan to shihana.rumzi@ontario.ca. within one week of receipt of this order by November 30, 2017.

Grounds / Motifs :

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

The home submitted a CIS report, to the MOHLTC on an identified date, indicating missing resident with injury. The CIS report stated resident #002 was last seen at 0545hrs, by the night staff prior to the end of their shift and then at

0730hrs, when a day shift staff member entered resident #002's room he/she observed the window on the floor and the resident was unable to be located. Code yellow was called and the police were notified when resident #002 was not found in the home. The resident was found at 0810hrs, at the rear of the home in his/her pajamas with one shoe missing. Resident #002 was returned to the home and was assessed and later transferred to hospital for further assessment. Resident #002 was returned to the home.

A review of resident #002's written plan of care prior to his/her identified responsive behaviour with-in two identified review periods did not contain a "Problem(s)", related to identified responsive behaviors as the resident did not present with these responsive behaviours in the past.

A review of the plan of care following the identified responsive behaviour confirmed by the home to be currently in effect with an identified date, indicate under the first "Problem(s)", the identified responsive behaviour and interventions indicated redirect when presenting with the responsive behaviour at night related to an identified health diagnosis is to assist to toilet, give snacks, every 15 minute security checks, sensor alarm installed on the bed and window area to alert staff when the resident gets out of bed or presents with the identified responsive behaviour. The second "Problem(s)", statement safety devices/restraints impaired mobility, related to an identified responsive behaviour. The intervention indicated the bed alarm and the window alarm to alert staff when the resident attempts to get up of his/her own or attempts to open window. The inspector did not see the "Monitor Check Room", sheet for the identified room included as an intervention for resident #002.

During the course of the inspection the inspector carried out multiple observations. During this time the inspector conducted interview related to observations:
On an identified date and time,
-The inspector observed a "Monitor Check Room", for an identified room to be on a clipboard outside of resident #002's room to be not completed. The room check indicated it is to be completed by the registered staff at the start of the shift. The inspector kept monitoring the check sheet till 1345hrs, when the inspector went to carry out another room observation for resident #002 the "Monitor Check Room", check sheet was still not completed at 1340hrs, till it was brought to RPN #112's attention.

An interview with Registered Practical Nurse (RPN) #112 indicated he/she was an agency staff from Staff Relief but has been coming to the home for the past three years. The RPN indicated he/she received report on an identified date, from the night staff related to resident #002 on the first floor. The RPN acknowledged that he/she did not check resident #002's room to complete the "Monitor Check Room ", and stated the room check was not on the written plan of care so he/she was unaware that he/she has to carryout "Monitor Check Room", and unaware it was a part of his/her duties on the day shift.

Interviews with PSW #107 and #113 indicated they were resident #002's primary PSWs. The PSWs indicated the resident presented with an identified responsive behaviour early this year and identified interventions where implemented to ensure the safety of resident #002. The PSW's acknowledged that there was a "Monitor Check Room", sheet outside resident #002's room. The PSW's reviewed the current written plan of care and stated that the plan of care didn't have the "Monitor Check Room", sheet as an intervention and didn't know whose duty it was to carry out the checks.

An interview conducted with the DOC indicated the written plan of care is to consist of information staff need to provide care to the resident and also safety measures in place if the resident has responsive behaviours or is exit seeking. The DOC stated resident #002 presented with an identified responsive behaviour early this year and has safety measures in place which includes a "Monitor Check Room", posted outside his/her room and it was to be carried out by the day nurse on the unit at the beginning of his/her shift. The DOC was provided with a copy of the written plan of care following the resident's responsive behaviour as confirmed by the home to be currently in effect with a identified print date. The DOC reviewed the written plan of care with the inspector and acknowledged he/she put the "Monitor Check Room", sheet in place as another step to ensure safety for resident #002 and the DOC further acknowledged that the written plan of care did not consist the "Monitor Check Room", sheet as an intervention. The DOC stated as the "Monitor Check Room", sheet was not included in the written plan of care and staff didn't have clear direction as to who is to carry out the "Monitor Check Room", sheet and when the check is to be done.

The home is being served an order as the severity of the non-compliance and the severity of harm and risk is actual as resident #002 presented with an identified responsive behaviour on an identified date, between the hours of 0545

- 0730hrs, and was found at 0810hrs, in the rear of the home in the forest area. The home put in place safety interventions which also included a "Monitor Check Room" sheet which was to be carried out at the beginning of the shift by the unit nurse on the first floor. The intervention put in place by the home to ensure the safety of resident #002 was not included in the written plan of care where by no clear direction was provided to staff and resident #002 was not provided a safe and secure environment.

The scope of the non-compliance is isolated.

A review of the home's compliance history revealed that the home has had previous noncompliance's issued related to the Long-Term Care Homes Act 2007, c. 8, s. 6 (1):
- Resident Quality Inspection, 2016_414110_0010, September 30, 2016 – VPC
- Resident Quality Inspection, 2015_168202_0013, August 17, 2015 – VPC
- Resident Quality Inspection, 2014_168202_0027, November 28, 2014 – VPC (604)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 01, 2018

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, commercial courier or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 23rd day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Shihana Rumzi

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