Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 3, 2014	2014_214146_0001	H-000019-14	Resident Quality Inspection

Licensee/Titulaire de permis

UNITED MENNONITE HOME FOR THE AGED
4024 Twenty-Third Street, Vineland, ON, L0R-2C0

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

UNITED MENNONITE HOME
4024 Twenty-Third Street, Vineland, ON, L0R-2C0

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

BARBARA NAYKALYK-HUNT (146), CAROL POLCZ (156), LESLEY EDWARDS (506), ROSEANNE WESTERN (508), THERESA MCMILLAN (526)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 8, 9, 13, 14, 15, 16, 17, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Environmental Supervisor, Food Services Manager (FSM), Dietitian, resident assessment instrument (RAI) coordinator, volunteer coordinator, registered staff, personal support workers (PSW's), hairdressing staff, volunteers, housekeeping staff, recreation staff, dietary aides, residents and family members.

During the course of the inspection, the inspector(s) reviewed resident health records; reviewed policy and procedures related to falls management, personal care, infection control, housekeeping, documentation, call bell system, medications, restraints, skin and wound, prevention of abuse, nutrition, recreation and responsive behaviours; reviewed committee meeting minutes for resident council, family council, professional advisory committee (PAC) and food committee; reviewed personnel records and education records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee failed to ensure that the resident was protected from abuse by a staff person.
(A) On a date in January 2014, the inspector witnessed a staff person being verbally abusive with a resident.
(B) On a date in January 2014 resident #722, residing on the same unit as (A), reported to an inspector that a staff person had been verbally abusive in the previous weeks.
(C) On a date in January 2014, resident #663 from the same living area as above reported that a particular staff person was rough with the resident. The resident was fearful of giving more information.
(D) On a date in January 2014 resident #685 on the same living area indicated that staff were rude and have said rude things when the resident asked for assistance. The resident did not wish to give further information.
(E) On a date in January 2014 resident #704 reported to an inspector and identified a different staff person who had been verbally abusive.

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. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The plan of care did not set out clear directions for the staff and others who

provided direct care to the resident.
A) The document known as the "care plan" for resident #681 directed staff to provide the resident with a supplement #1 at breakfast, lunch and supper. The plan also indicated to provide a different supplement #2 at morning, afternoon and bedtime snack. An instruction sheet in the servery listing residents who were to receive supplements was not up to date as it did not include resident #681. The volunteer who was feeding resident #681 on a date in January 2014 was unsure if the resident was to receive a supplement and did not know what the supplement would be. Staff who were present interjected and indicated that the resident was receiving a third type of supplement #3. The health record indicated that the third type of supplement was discontinued in December 2013 and replaced with supplement #2. The directions related to the resident's supplement were unclear. This information was confirmed by the RD.
(B) During meal observation in January 2014 the FSM confirmed that documentation in a servery was unclear. An instruction sheet on the bulletin board indicated that resident #681 was to receive a powder supplement and on the same sheet in another box, a liquid supplement.
(C) The therapeutic snack list provided to the inspector in January 2015 indicated that resident #681 was to be provided with a certain supplement which the health record indicated was discontinued in December 2013.
(D)Documented directions in a servery during the observed lunch in January 2014 indicated that the resident was to have an identified supplement at bedtime, however, orders on the health record did not include any supplementation. This was confirmed with the FSM.
(E) The special snack written directions provided by the FSM in January 2014 indicated that the resident was to be provided with a specific supplement. The FSM confirmed that there was not a physician's order for the supplement. The FSM indicated that it should have been a different supplement although this supplement was discontinued in December 2013. The directions were unclear. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.
A) The plan of care and current orders for resident #681 indicated that a supplement was to be provided. During the observed lunch meal in January 2014, it was confirmed that the dietary aide did not provide resident #681 with the ordered supplement. The RAI coordinator, RD, FSM and health record confirmed that the supplement was not given three times per day as ordered.
B) Resident #710 had an order discontinuing a supplement. However, POC

documentation indicated that a supplement was provided without a current order for any supplement. This was confirmed by the RD. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions for the staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee of the home did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.
(A) The home's policy 04.02.01 Physician's Orders indicated that any changes to the diet order must be approved by the physician or RD. An order written by the RD for resident #681 to change supplements was not signed by the RD or the physician. The RD confirmed that she wrote the order but failed to sign it.
(B)The home's policy 07.02.01 Documentation Guidelines indicated that all typed records must be current, complete, accurate, correctly spelled and provide clear explanations in medical terms. The policy was not followed as a typed record was not found to be accurate. The POC documentation for supplement was signed as given. As confirmed by the RD during interview this was done in error during a training session with the RAI coordinator however, was not 'stricken out' as an error.
(C) The home's policy entitled Documentation Guidelines 07.02.01 indicated that all typed and written records must be accurate. In January 2014 at an identified time, staff documented in resident #688's POC task list that the call bell was within reach of the resident. When the room was observed on the same morning, there was no call bell present at all in the room. Staff present confirmed that there was no call bell present.
(D) The home's policy on resident abuse 1.1.13 dated November 17, 2011 indicated that the home was to use a checklist entitled Resident Abuse and Neglect Policy and Procedure Checklist. This checklist is to be used for staff training and education to ensure staff have read the policy and understands the policy on resident abuse. The DOC and administrator confirmed that the home has not been using this checklist. [s. 8. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee did not ensure that all doors leading to the outside of the home, other than doors leading to secure outside areas, that preclude exit by a resident, including balconies and terraces, were consistently kept closed and locked.
In January 2014, a door leading to the balcony outside of the home was closed but not locked. The outside temperature was -18C and ice covered snow was observed over the entire balcony area. Staff confirmed that the door should have been closed and locked. [s. 9. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to the outside of the home, other than doors leading to secure outside areas, that preclude exit by a resident, including balconies and terraces, are consistently kept closed and locked, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee failed to ensure that all staff in the home had received the required training on zero tolerance of abuse and neglect of residents.
(A) During an interview with the hairdressing staff both hairdressers confirmed that they had not received any training from the home on abuse and neglect of residents.
(B) During an interview with three PSW's, they could not confirm that they had training on prevention of abuse and neglect of residents.
(C) During an interview, a volunteer in the home stated that no training on abuse and neglect of residents was provided to the volunteer. [s. 76. (2) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff in the home receive the required training on zero tolerance of abuse and neglect of residents, 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. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

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 did not ensure that the infection prevention and control program was evaluated and updated at least annually in accordance with evidence-based practices or prevailing practices. The DOC confirmed that an evaluation of the home's infection prevention and control program had not been done. [s. 229. (2) (d)]

2. Staff did not participate in the implementation of the infection prevention and control program.
(A) In January 2014: used and unlabelled hairbrushes, combs, deodorants and creams were observed in tub room 223; bathrooms in two shared rooms contained unlabelled toothbrushes and an unlabelled denture container and soiled laundry was observed on the hallway floor in a resident care area.
(B) In January 2014: unlabelled personal care items were found in a tub room and in bathrooms of shared resident rooms including a room with isolation precautions. The DOC and staff confirmed that personal items should be labelled and should be thrown out if staff find unlabelled resident personal care items in shared areas. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the infection prevention and control program is evaluated and updated at least annually in accordance with evidence-based practices or prevailing practices and ensure that staff participate 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that resident's privacy was respected during treatments.
In January 2014, three residents in the lounge areas were observed receiving eye drops administered by registered staff, in the presence of other residents. The DOC confirmed that staff are to ensure privacy while providing treatments. [s. 3. (1) 8.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the home, furnishings and equipment were kept clean and sanitary. In January 2014 three residents were seated in wheelchairs that were visibly soiled on the arms and on the back panel of the chairs. In January 2014 one wheelchair and three walkers being used by residents were observed to be soiled on the handles, footrests and back panel of the chair. Two housekeeping staff and the environmental manager confirmed that they had not been able to follow the wheelchair/walker cleaning schedule. [s. 15. (2) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The home did not ensure that the home's resident-staff communication and response system was easily seen, accessed and used by residents, staff and visitors at all times.
(A) In January 2014, it was observed that resident #688 had no bedside call bell present or installed. There was a bed alarm present on the mattress and attached to the wall unit where the call bell would be attached. Staff confirmed that the resident had no call bell.
(B) In January 2014, it was observed that resident #687 and resident #693's bathroom call bell cords were tied around the grab rail in their respective bathrooms, thereby rendering the bells non-operational from the toilet seat.
(C) In January 2014, it was observed that resident #697's bedside call bell was not accessible to the resident while seated in the chair. The call bell cord was on the floor behind the bed.
(D) In January 2014 and again on January 14, 2014, resident #506's bathroom call bell was wrapped around the grab bar, thereby rendering the bell non-operational from the toilet seat.
This information was confirmed by observation and staff confirmation. [s. 17. (1) (a)]

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

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. r. 30. (2)
The health record of resident #722 documented a skin impairment. No assessments of the area were documented as confirmed by the RPN.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all areas where medications are stored are kept secured and locked at all times.
In January 2014 it was observed that the medication room door was left unlocked and unsupervised and medications were accessible in an unlocked cupboard and drawer. When interviewing the registered staff on duty they confirmed that the door was unlocked and verified the door should be locked at all times. [s. 129. (1) (a)]

Issued on this 6th day of February, 2014

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

BARBARA NOYKALYK - Hewitt

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BARBARA NAYKALYK-HUNT (146), CAROL POLCZ (156), LESLEY EDWARDS (506), ROSEANNE WESTERN (508), THERESA MCMILLAN (526)
Inspection No. / No de l'inspection :	2014_214146_0001
Log No. / Registre no:	H-000019-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 3, 2014
Licensee / Titulaire de permis :	UNITED MENNONITE HOME FOR THE AGED 4024 Twenty-Third Street, Vineland, ON, L0R-2C0
LTC Home / Foyer de SLD :	UNITED MENNONITE HOME 4024 Twenty-Third Street, Vineland, ON, L0R-2C0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	RON WIENS

To UNITED MENNONITE HOME FOR THE AGED, 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

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all residents are protected from abuse by staff and are not neglected by the licensee or staff. The plan is to be submitted to Lesley Edwards by end of business day February 17, 2014 by mail at 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7 or by e-mail to lesley.edwards@ontario.ca.

Grounds / Motifs :

1. Previously issued June 1, 2011 as a WN.
The Licensee failed to ensure that the resident was protected from abuse by a staff person.
A) On a date in January 2014, the inspector witnessed a staff person being verbally abusive with a resident.
B) On a date in January 2014 resident #722, residing on the same unit as (A), reported to an inspector that a staff person had been verbally abusive in the previous weeks.
C) On a date in January 2014, resident #663 from the same living area as above reported that a particular staff person was rough with the resident. The resident was fearful of giving more information.
D) On a date in January 2014 resident #685 on the same living area indicated that staff were rude and have said rude things when the resident asked for assistance. The resident did not wish to give further information.
E) On a date in January 2014 resident #704 reported to an inspector and identified a different staff person who had been verbally abusive.

(506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 17, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 3rd day of February, 2014

Signature of Inspector / Signature de l'inspecteur : BARBARA NAYKALYK-HUNT

Name of Inspector / Nom de l'inspecteur : BARBARA NAYKALYK-HUNT

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