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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 5, 2015	2015_324567_0004	T-1702-15	Resident Quality Inspection

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite #200 MARKHAM ON L3R 0E8

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

LEISUREWORLD CAREGIVING CENTRE - ALTAMONT
92 ISLAND ROAD SCARBOROUGH ON M1C 2P5

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

SOFIA DASILVA (567), GORDANA KRSTEVSKA (600), JULIET MANDERSON-GRAY (607), SUSAN SEMEREDY (501)

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): May 12, 13, 14, 15, 19, 20, 21, 22, 25, 26, 28, and 29, 2015.

The following intakes were conducted concurrently with the Resident Quality Inspection: T-8434-15, T-1466-14, T-5543-14, T-814-13 and T-2456-15.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Assistant Director of Care (ADOC), Director of Dietary Services (DDS), Registered Dietitian (RD), Social Worker, Physiotherapist, Environmental Services Manager (ESM), Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, Registered Staff, Personal Support Workers (PSWs), Dietary Aides, Cooks, Housekeeping Staff, Residents, Substitute Decision Makers (SDMs), family members, presidents of Resident and Family Council.

During the course of the inspection, the inspector(s)conducted a tour of the home, made observations of meal service, medication administration system, staff and resident interactions and the provision of care, reviewed resident health records, complaint and critical incident record logs, staff training records, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **14 WN(s)**
- **6 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 53. (1)	CO #001	2014_163109_0034	501

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. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home are kept inaccessible to residents at all times.

On May 12, 2015, the inspector observed that various bathroom, storage and housekeeping rooms were open and accessible to residents and contained hazardous cleaning substances in unlocked cupboards:
• Wing one housekeeping closet found open and had open containers of Accel wipes, Accel One Step Surface Cleaner and Disinfectant with accelerated hydrogen peroxide and a Virudex 7 jug open and sitting in hanger on the wall;
• Wing two bathroom found unlocked and had open containers of Accel One Step Cleaner and Disinfectant with accelerated hydrogen peroxide; and
• Wing four housekeeping closet found unlocked with open containers of Accel wipes, Jupiter 11 Citrus All-Purpose Cleaner in unlocked cupboard and Virudex 7 jug open and sitting in hanger on the wall.

On May 15, 2015, the inspector observed:
• Wing four housekeeping closet found unlocked and a Virudex 7 jug open and sitting in hanger on the wall.

On May 21, 2015, the inspector observed:
• Wing three housekeeping closet unlocked and various chemicals in unlocked cupboards and shelves including:
o Venus Pro Creme Cleanser
o Venus Bowl Power (poison, corrosive)
o Virox 5RTU Surface Cleaner and Disinfectant
o Accel Intervention Wipes
o Chemysyn Glass Cleaner
o Odorless Drain Opener (causes severe burns on contact)
o Jupiter 11 All Purpose Citrus CleanerRust and
o Tannin Spotting Agent #3 (causes burns to exposed skin and eyes)

Interview with PSW #139 and the ESM confirmed that the above-mentioned doors should be kept locked. The inspector and the ESM toured the home on May 21, 2015, and found various doors open and unlocked including three bathrooms and a housekeeping closet. Interview with the ESM confirmed that the staff are leaving these doors open and some of the locks and closing mechanisms of the doors are faulty. The ESM confirmed that these doors should be kept locked in order to keep hazardous chemicals inaccessible to residents at all times.

On May 28, 2015, even after confirming with the ESM that the above-mentioned doors should be kept locked so that hazardous chemicals are inaccessible to residents,

inspectors #501 and #567 made the following observations:
• Wing three bathroom found unlocked with bottle of Virudex 7 in unlocked cupboard;
• Wing two bathroom door found ajar with bottle of Accel One Step Cleaner in unlocked cupboard. The ESM witnessed this as well;
• Cleaning cart on wing four found unlocked and contained:
• Venus Pro Creme Cleanser
• 3MTtrouble Shooter Cleaner for removing soil and wax build up
• Toilet Bowel Cleaner (poison, corrosive)
• Virudex 7

Interview with ED confirmed that these doors and housekeeping carts should be kept locked and hazardous chemicals inaccessible to residents at all times. [s. 91.]

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

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

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences.

A review of resident #003's MDS records dated February, 2015, revealed that the resident was assessed as being bedfast.

An interview with resident #003's private caregiver #133, PSW #123 and registered staff #128 revealed that the resident is bedfast as the resident refuses to get out of bed and that furthermore, this is his/her preference.

A review of resident #003's plan of care could not locate any interventions relating to resident #003's preference to stay in bed or a reason for being bedfast.

An interview with the DOC confirmed that if a resident is bedfast, interventions relating to this preference should be included in the resident's written plan of care. [s. 6. (2)]

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

Record review of the current written plan of care revealed that resident #026 required one staff to assist with showering twice weekly and as necessary. Interview with PSW #126 revealed this resident had not been provided a shower for the past month because when he/she was positioned in the shower chair he/she leaned to one side and PSW #126 felt it was unsafe because the resident could fall. Interview with registered staff #114 revealed he/she was aware of having a conversation with this identified PSW regarding resident #026 being unsafe in a shower chair and agreed that the resident should be given bed baths. He/she further stated he/she did not document her assessment or revise the plan of care. Interview with the DOC revealed that he/she believed resident #026 was receiving bed baths because of a particular health condition.

The DOC confirmed that staff did not collaborate with each other in the assessment of the resident. [s. 6. (4) (a)]

3. The home has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

On May 21, 2015, observations revealed that during breakfast, resident #004 was served hot cereal in a plastic mug and eggs and toast on a regular plate. Review of the diet serving list revealed that resident #004 had specific needs relating to food service.

Interview with the DDS revealed resident #004's plan of care did not specify the use of specific food service needs for cereal but did specify the serving of meals using specific service ware. The DDS confirmed that resident #004 was not provided the care as set out in the plan of care. [s. 6. (7)]

4. Record review revealed that resident #007 was assessed by the physician in April, 2015. At this time, an order to adjust the resident's identified medication was made as well as an order to monitor the resident's weight weekly for a specified duration of time. Record review revealed that weights were not recorded the weeks of April 6 and May 4, 2015.

Interview with registered staff #115 and the DOC confirmed that weights for resident #007 were not taken as specified in the written plan of care. [s. 6. (7)]

5. The licensee has failed to ensure that staff and others who provide direct care to the resident are kept aware of the contents of the plan of care and have convenient and immediate access to it.

Record review of the most recent plan of care revealed that resident #023 had specified responsive behaviours and staff were to remind the resident not to help or assist in any way with other residents who have dementia.

Interview with PSW #121 revealed that he/she was not aware of this issue for resident #023, had not checked the entire plan of care and only had access to the kardex. Interview with the DOC revealed that all PSWs have access to the plans of care on a desktop computer however interviews with PSWs #121, 122 and 127 confirmed that they do not check these plans of care and rely on the residents' kardexes and verbal communication with staff.

The DOC confirmed that the PSWs who provide direct care did not have convenient and immediate access to the plans of care. [s. 6. (8)]

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 is based on an assessment of the resident and the resident's needs and preferences,
-staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other,
-the care set out in the plan of care is provided to the resident as specified in the plan,
-staff and others who provide direct care to the resident kept aware of the contents of the plan of care and have convenient and immediate access to it,, to be implemented voluntarily.

WN #3: 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 has failed to ensure that the home, its furnishings and equipment are kept clean and sanitary.

On May 12, 2015, the following observations were made in the common areas:
• On wing three: dirty floor and towel warmer were observed in a bathroom; a lingering smell of urine was noted; and dirty window sills were noted to be filled with dead flies
• In the small corner of the dining room, the screens on the windows were noted to be full of dirt, debris, and dead flies; in the larger part of the dining room, the windows and radiators located immediately adjacent to resident dining tables were caked with food.

The following observations were made in resident rooms:
• On May 13 and 21, 2015, in room 212, a resident's personal items displayed on a dresser were observed to be very dusty;
• On May 20 and 21, 2015, in room 113, the surface of a high dresser was observed to be very dusty.

Interviews with the ESM confirmed the above-noted areas had not been kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home is maintained in a safe condition and in a good state of repair.

Review of an anonymous complaint letter addressed to the ED of the home and copied to the Ministry of Health and Long-Term Care and the home's corporate office dated April 22, 2015, revealed that the roof had been leaking into resident rooms. Interview with the ESM and ED revealed that the home had been experiencing water leakage from the roof for approximately two years. For the last two years the home had experienced ice melting issues in the spring and in the fall of 2014 the home put in heat tracer cables. This did not solve the problem and on April 20, 2015, a strong rainstorm caused water to come into three resident rooms on wing three. The home indicated that plans were in place to replace the roof on wing three, with work scheduled to start in June 2015.

Interview with the DOC confirmed that the home was not maintained in a good state of repair. [s. 15. (2) (c)]

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 home, its furnishings and equipment are kept clean and sanitary and to ensure that the home is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

A review of the resident's plan of care revealed that resident #004 had an alteration in skin integrity in April, 2015.

An interview with staff #105 on May 14, 2015, revealed that resident #004's family had communicated to the home staff that the resident experienced pain during dressing changes. The staff also revealed that as a result of this conversation, Tylenol was ordered and was to be given one hour prior to dressing changes. Review of the physician's orders, dated May 13, 2015, revealed an order for an analgesic, to be administered by mouth, one hour prior to dressing changes.

A review of the resident's electronic medication administration record and interview with registered staff #120 revealed that resident #004 did not receive analgesic prior to pressure ulcer dressing changes to reduce or relieve pain, between April 1, and May 13, 2015.

An interview with the DOC confirmed that those residents with alterations to their skin integrity, who are unable to verbalize, must be treated for pain. [s. 50. (2) (b) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours.

Record review revealed that resident #021 had identified responsive behaviours. The plan of care directed staff to not wake resident #021 in the morning and to provide care as per the plan related to meal service. Record review and interview with PSW #102 revealed that resident #021 often went to the main dining room for breakfast. Interview with an identified ADOC revealed resident #021 often refused identified care requirements and became agitated especially on days where these specific care requirements were implemented and would exhibit responsive behaviours.

The ADOC revealed that staff should follow the plan of care related to meal service.

Interview with the DOC confirmed that staff did not implement strategies to respond to resident #021's responsive behaviours. [s. 53. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

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

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(b) a cleaning schedule for all the equipment; and O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all menu substitutions are communicated to residents and staff.

On May 12, 2015, observations made in the dining room at lunch revealed that mangos were served as a dessert option. Review of the menu board and the planned menu for the day revealed that strawberries with whipped cream were to be offered for lunch on this day.

Interview with the DDS revealed that the dietary staff used all the strawberries the previous day for a mixed berry dessert and confirmed that the substitution of mangos for strawberries with whipped cream was not communicated to residents and staff. [s. 72. (2) (f)]

2. The licensee has failed to ensure that there is a cleaning schedule for all the equipment related to the food production system, dining and snack areas and that staff comply with this schedule.

On May 21, 2015, observations made in the kitchen revealed that many carts, the back of a stainless steel counter and a fan were dirty. Interview with the DDS revealed that these items were not on the cleaning schedule.

On the same day, observations made in the dining room revealed that plastic tents covering meal service information on the tables were dirty. Interview with the DDS revealed these table tents were on the cleaning schedule and should have been cleaned the previous Sunday. The DDS confirmed that they had not been cleaned as scheduled. [s. 72. (7) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all menu substitutions are communicated to residents and staff and to ensure that there is a cleaning schedule for all the equipment related to the food production system, dining and snack areas and that staff comply with this schedule, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

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

Findings/Faits saillants :

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

On May 12, 2015, the inspector observed PSW #140 in the dining room at lunch standing at the servery, fanning herself with a diet serving list while resting her foot on the bottom shelf of the food cart. The inspector noted that resident's food was being stored on the bottom shelf of the cart. Interview with PSW #140 revealed that she knew that resting her foot on the food cart was wrong but did not wish to offer an explanation as to why she had done so. Interview with the DDS and DOC confirmed that this is an infection control issue as this was a potential source of contamination of the resident's food.

On May 12, 13 and 14, 2015, the following observations were also made:

• In a shared washroom in room 207, there were unlabelled plastic glasses and a toothbrush;
• In room 201, there was a shower caddy left on a resident's night stand which contained: a used glove; CavilonTM cream with another resident's name on it; a dirty teaspoon; a plastic teaspoon; a rolled up tissue and a used disposable razor;
• At a shared sink station in room 406, there were unlabelled toothbrushes;
• In a shared washroom in room 209, there was an unlabelled toothbrush and a bar of soap in a pink kidney dish;
• In a shared washroom in room 205, there was an unlabelled toothbrush and hair brush;
• In a shared washroom in room 212, there were unlabelled dirty urine hats, and
• In a plastic storage tower, labelled nail clippers were noted stored inside labelled drawers; and in the same storage tower, in one larger drawer there were two labelled clippers, each labelled with a different resident name, stored side by side. The nail clippers both appeared used.

On May 21, 2015, observations revealed that plastic tents covering meal service information, and salt and pepper shakers were dirty and grimy. Interview with the DDS revealed these items had not been cleaned as scheduled.

Interview with the DOC confirmed that the above-mentioned observations revealed that staff were not participating in the implementation of the infection prevention and control program. Also, interview with the DOC confirmed that not cleaning these items is an infection control issue and they should be cleaned on a daily basis. [s. 229. (4)]

2. On May 19, 21, and 26, 2015, the inspector observed registered staff #106, #107, and #120 administering medication without performing hand hygiene between medication administration passes from one resident to another.

A review of the home's policy, titled, Infection control - Hand hygiene, version V6-090, revised August 2013, indicated that staff should perform hand hygiene before preparing medication in order to protect the resident.

Interview with registered staff #107 and the DOC confirmed that staff must perform hand hygiene between administration of medications for each resident. [s. 229. (4)]

3. The licensee has failed to ensure that on every shift, symptoms of infection are recorded and that immediate action is taken as required.

A review of resident #005's clinical record revealed that the resident experienced upper respiratory infection symptoms on a specified date in February 2015, and was assessed by his/her attending physician. He/she was treated with antibiotics in the home until a specified date. A review of the clinical record revealed that symptoms were not recorded on the following shifts:
A specified date in February 2015 – night and evening shifts
A specified date in February 2015 – night and evening
A specified date in February 2015 – day shift
A specified date in February 2015 – evening shift
A specified date in February 2015– evening shift
A specified date in February 2015 – night shift

An interview with registered staff #103 confirmed that the practice in the home is to monitor and record resident symptoms every shift while the resident is on antibiotics. Staff confirmed that there was no record of symptoms for the above -identified shifts for resident #005. [s. 229. (5) (b)]

4. The licensee has failed to ensure that there is a hand-hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents.

Throughout the course of the inspection, it was noted that there were a number of resident rooms where there was only a toilet in the washroom. A shared sink station was noted to be located outside the washroom in the residents' room. On May 22, 2015, this was observed in several identified resident rooms. In addition, in each of the above-noted resident room washrooms, there was no access to point of care hand hygiene agents.

Interview with the DOC confirmed that this is an infection control issue because after using the toilet, a resident and/or a person assisting with toileting and care does not have the ability to clean their hands before touching the door knob to exit the washroom. [s. 229. (9)]

5. The licensee has failed to ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Record review revealed that resident #007 was admitted to the home a specified date in

2013, and was not screened for tuberculosis until several months later in 2013. Interview with the DOC confirmed that the resident was not screened for tuberculosis within 14 days of admission and that he/she had also not been screened in the 90 days prior to admission. [s. 229. (10) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that
-staff participate in the implementation of the infection prevention and control program,
-on every shift, symptoms of infection are recorded and that immediate action is taken as required,
-there is a hand-hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents,
-each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
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).

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

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

On May 12, 2015, observations during the lunch meal service revealed that the dining experience did not respect and promote the residents' right to be treated with courtesy and respect. The following observations were made:

• The noise level was exceptionally loud due to: dragging of chairs on the floor in between the first and second sittings, washing of dishes from the kitchen area, intermittent beeping of the dishwasher from the kitchen and call bells from the nursing station;
• PSWs #130 and #142 were noted to be speaking with one another over the tops of residents' heads while they were assisting with feeding;
• PSW #140 was observed fanning herself with a diet list at the servery while resting her foot on a food cart. Interview with PSW #140 confirmed that she should not be standing this way; and,
• A show plate of a menu option consisting of a salmon sandwich that was displayed to residents appeared crushed and unrecognizable. Interview with PSW #141 confirmed that this was not acceptable and replaced it with a new one.

Interview with the DDS revealed she was aware of the noise level in the dining room but due to the close proximity of the dining room to the kitchen and nursing station, it was difficult to alleviate. The DDS revealed that staff could decrease the noise level by not dragging chairs on the floor. The DDS confirmed that PSWs assisting residents with feeding should not be carrying on conversations over residents' heads and in addition, the identified PSW who was fanning herself, appeared disrespectful. The DDS confirmed that show plates should be presentable and reflective of the menu option. The DDS confirmed that this atmosphere during dining did not fully promote the residents' right to be treated with courtesy and respect. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be told who is responsible for and who is providing the resident's direct care.

On May 12, 2015, the inspector observed PSWs #140 and #122 in the dining room without name tags.

Interview with these PSWs revealed that as a result of the corporate name change from Leisureworld Senior Care Corporation to Sienna Senior Living Incorporated, staff received new cards from head office and these new cards did not have their names displayed on them. Interview with the DOC revealed that the company is considering an alternative name identification system but for the time being the staff should be using their old name tags.

Interview with the DDS and DOC confirmed that residents have the right to know who is

providing direct care to them and the identified PSWs should wear name tags visible to the residents. [s. 3. (1) 7.]

3. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

On May 28, 2015, at 11:30a.m., the inspector observed staff #129 providing identified care to resident #050; the privacy curtain was not drawn. Resident #050's roommate, resident #051, was sitting close by watching television. Resident #051 was able to observe the care being provided to resident #050.

An interview with the staff #129 confirmed that the curtains were not drawn and that he/she should have provided privacy to resident #050 by drawing the curtain.

An interview with the DOC confirmed that if staff do not fully draw the privacy curtain around a resident's bedspace while they are providing care, they are not promoting the residents right to be afforded privacy in treatment and in caring for his or her personal needs. [s. 3. (1) 8.]

4. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act.

The inspector observed that the computer screen was not locked and resident's personal health information was visible to anyone passing by on the following dates:
-On May 15, 2015 at 11:30a.m.
-On May 19, 2015 at 1:20p.m.
- On May 21, 2015 at 7:35a.m.
-On May 21, 2015 at 7:50a.m.
-On May 21, 2015 at 8:31a.m.

Interviews with registered staff #105, #106, #107 and #118 confirmed that they did not lock the screen when they were no longer in use.

Interview with the DOC confirmed that staff must lock the screen when they finish checking the medication administration record. [s. 3. (1) 11. iv.]

5. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

On May 13, 2015, while the inspector was in the process of interviewing resident #010 in his/her room, the following series of events were observed to occur: staff #119 knocked and entered the room without waiting for the resident to respond and without asking if he/she could interrupt. He/she then proceeded to ask resident #010 if they would like a drink. The staff then left the room for a minute, came back with a glass of juice, accompanied by registered staff #120, who brought with him/her a blood pressure monitor to check resident #010's vital signs. Neither staff asked resident #010 if he/she was agreeable to the interruptions so they could perform their tasks. The inspector was seated in the resident's room, by the resident, throughout this series of events.

An interview with the resident confirmed that staff members do this sometimes and that he/she was very upset about it. Also, the resident indicated that he/she had told staff about how he/she felt but staff continued to do this. [s. 3. (1) 14.]

WN #9: 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 cannot be opened more than 15 centimetres.

On May 12, 2015, the inspector observed that the bathroom and a storage room on wing two were unlocked and accessible to residents. It was also observed that in these two rooms there were windows that could be opened approximately 20 centimeters.

Interview with the ESM revealed that these windows should have chains on them to prevent them from opening more than 15 centimetres. The inspector observed that later in the day the windows had chains on them and could not be opened more than 15 centimetres. [s. 16.]

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

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

Interview with staff #140 and inspector observations of resident #005 revealed that he/she had specific preferences relating to time in bed as well as when to get up for showers.

A review of the MDS assessment record and interview with staff #140 confirmed that resident #005 is bedfast and that he/she prefers to stay in bed all or most of the time.

Record review and interview with staff #140 confirmed that there was no written plan of care to reflect resident #005's sleep patterns and preferences and his/her wish to stay in bed and to get up only when he/she prefers for showers. [s. 26. (3) 21.]

WN #11: 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 :

1. The licensee has failed to ensure that planned menu items are offered and available at each meal and snack.

On May 12, 2015, observations made in the dining room at lunch revealed that mangos were served as a dessert option. Review of the menu board and the planned menu for the day revealed that strawberries with whipped cream were to be offered for lunch on this day.

Interview with the DDS revealed that the dietary staff used all the strawberries the previous day for a mixed berry dessert and confirmed that the planned menu item was not available at this meal. [s. 71. (4)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques are used to assist residents with eating.

On May 21, 2015, the inspector observed PSW #142 assisting resident #004 with eating pieces of toast at breakfast, while standing. Interview with the identified PSW revealed she was aware she should be sitting to assist with feeding but indicated there was no room to place a chair beside the resident.

Review of the home's policy, titled, Mealservice-Eating Assistance, version V9-305, stated the individual providing assistance to a resident should be sitting at eye level.

Interview with the DDS confirmed that PSW #142 should have been seated while providing eating assistance to resident #004. [s. 73. (1) 10.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed no later than one business day of an environmental hazard, including a breakdown of major equipment or a system in the home that affects the provision of care or safety, security or well-being of residents for a period greater than six hours.

Review of a critical incident report submitted to the Ministry of Health and Long-Term Care by the home on September 17, 2014, revealed that the home's call bell system failed the evening of September 10, 2015, and the system was not restarted until September 17, 2015. Interview with the ESM revealed that the call system failed on the evening of September 10, 2014, at approximately 8:00 p.m. and the home's service provider did not come to the home until the next day. The service provider was able to restart the system, with the exception of one room on September 11, 2014, at approximately 12:00 p.m. It then took the service provider until September 17, 2014, to fix all call bells and the system had to be turned on and off intermittently in order to do so.

Interview with the ED confirmed that the home failed to ensure that the Director was informed no later than one business day of a breakdown of a major system in the home that affects the provision of care or safety, security or well-being of residents for a period greater than six hours. [s. 107. (3) 2.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A review of resident #031’s written plan of care revealed a number of medical diagnoses. A review of the physician orders for resident #031 revealed an order for an identified medication and related interventions. A review of the resident’s clinical record revealed that on specified dates in May 2015, staff implemented the medication interventions. A review of the progress notes indicated that staff could not complete the medication interventions as ordered.

A review of the resident's clinical record revealed that the above medication incidents were not documented and that the SDM, the DOC and the physician had not been notified.

Interview with the DOC confirmed that staff had not reported these incidents. [s. 135. (1)]

Issued on this 17th day of November, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SOFIA DASILVA (567), GORDANA KRSTEVSKA (600), JULIET MANDERSON-GRAY (607), SUSAN SEMEREDY (501)
Inspection No. / No de l'inspection :	2015_324567_0004
Log No. / Registre no:	T-1702-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 5, 2015
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	LEISUREWORLD CAREGIVING CENTRE - ALTAMONT 92 ISLAND ROAD, SCARBOROUGH, ON, M1C-2P5
	Deborah Rivett

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 Administrator /
Nom de l'administratrice ou de l'administrateur :

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., 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. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Order / Ordre :

The licensee shall prepare and submit a plan to ensure that all hazardous chemicals are kept inaccessible to residents at all times. The plan will include, at a minimum, and not limited to, the following elements:
-Education, including what constitutes hazardous chemicals, and why they need to be stored properly and safely. Please include which staff members will receive education as well as who will provide it.
-A review of which doors were found unlocked and/or open and an assessment of whether these doors can be equipped with an improved locking mechanism.
-A daily process for checking the doors. This may include the incorporation or introduction of tools into the daily housekeeping routine, such as the use of a checklist or a schedule, to ensure doors are locked.
-A quality management process or another system for the ongoing monitoring of the doors. This may include a plan that outlines how the long-term monitoring of the doors will proceed.

For all the above, as well as for any other elements included in the plan, please include who will be responsible for achieving compliance, for each part of the plan.

Please submit the plan to Susan.Semeredy@ontario.ca no later than October 13, 2015.

Grounds / Motifs :

1. Based on the number of observations of hazardous substances being accessible to residents, made by the inspector on four separate days and the repeated failure of the home to take action to ensure chemicals are stored safely, as well as a compliance history that includes a previously issued

Voluntary Plan of Correction, this compliance order is being issued to the home.

The licensee has failed to ensure that all hazardous substances at the home are kept inaccessible to residents at all times.

On May 12, 2015, the inspector observed that various bathroom, storage and housekeeping rooms were open and accessible to residents and contained hazardous cleaning substances in unlocked cupboards:
• Wing one housekeeping closet found open and had open containers of Accel wipes, Accel One Step Surface Cleaner and Disinfectant with accelerated hydrogen peroxide and a Virudex 7 jug open and sitting in hanger on the wall;
• Wing two bathroom found unlocked and had open containers of Accel One Step Cleaner and Disinfectant with accelerated hydrogen peroxide; and
• Wing four housekeeping closet found unlocked with open containers of Accel wipes, Jupiter 11 Citrus All-Purpose Cleaner in unlocked cupboard and Virudex 7 jug open and sitting in hanger on the wall.

On May 15, 2015, the inspector observed:
• Wing four housekeeping closet found unlocked and a Virudex 7 jug open and sitting in hanger on the wall.

On May 21, 2015, the inspector observed:
• Wing three housekeeping closet unlocked and various chemicals in unlocked cupboards and shelves including:
o Venus Pro Creme Cleanser
o Venus Bowl Power (poison, corrosive)
o Virox 5RTU Surface Cleaner and Disinfectant
o Accel Intervention Wipes
o Chemysyn Glass Cleaner
o Odorless Drain Opener (causes severe burns on contact)
o Jupiter 11 All Purpose Citrus CleanerRust and
o Tannin Spotting Agent #3 (causes burns to exposed skin and eyes)

Interview with PSW #139 and the ESM confirmed that the above-mentioned doors should be kept locked. The inspector and the ESM toured the home on May 21, 2015, and found various doors open and unlocked including three bathrooms and a housekeeping closet. Interview with the ESM confirmed that the staff are leaving these doors open and some of the locks and closing mechanisms of the doors are faulty. The ESM confirmed that these doors should

be kept locked in order to keep hazardous chemicals inaccessible to residents at all times.

On May 28, 2015, even after confirming with the ESM that the above-mentioned doors should be kept locked so that hazardous chemicals are inaccessible to residents, inspectors #501 and #567 made the following observations:
• Wing three bathroom found unlocked with bottle of Virudex 7 in unlocked cupboard;
• Wing two bathroom door found ajar with bottle of Accel One Step Cleaner in unlocked cupboard. The ESM witnessed this as well;
• Cleaning cart on wing four found unlocked and contained:
• Venus Pro Creme Cleanser
• 3MTtrouble Shooter Cleaner for removing soil and wax build up
• Toilet Bowel Cleaner (poison, corrosive)
• Virudex 7

Interview with ED confirmed that these doors and housekeeping carts should be kept locked and hazardous chemicals inaccessible to residents at all times.
Interview with ED confirmed that these doors and housekeeping carts should be kept locked and hazardous chemicals inaccessible to residents at all times.
(501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 5th day of October, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sofia daSilva

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