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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 5, 2013	2013_103193_0008	T-204-13	Resident Quality Inspection

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6

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

CASTLEVIEW WYCHWOOD TOWERS
351 CHRISTIE STREET, TORONTO, ON, M6G-3C3

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

MONICA NOURI (193), AMANDA WILLIAMS (101), JANET MCPARLAND (142), LYNDA HAMILTON (124), LYNN PARSONS (153), RUTH HILDEBRAND (128)

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 27, 28, 29, 30, 31, June 3, 4, 5, 6, 7, 10, 11, 12, 2013

During this inspection the following complaint logs were inspected: T-1225-12,T-1347-12 and T-1653-12.
During this inspection a follow up inspection was conducted T- 2189-12.

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Administrator, Director of Nursing (DON), Physicians, Nurse Managers (NM), Dietitians, Nutritional Managers, Building and Services Manager (BSM), Program Services Manager, Staff Development Educator, Infection Control Manager, Physiotherapists, Rehabilitation assistant, Recreation assistant, Support admissions, Support Assistant Administration, Maintenance and Laundry staff, Registered staff, Personal Care Aides (PCA), Residents and Family members

During the course of the inspection, the inspector(s) observed dining services, medication administration, provision of resident care, staff/resident interactions, review health records, home's policies and procedures, staff training records, residents and staff immunization, home's complaints record

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

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Reporting and Complaints

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Trust Accounts

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

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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. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary as follows.

Call bell strings were noted to be soiled with feces and other substances in the following areas of the home on June 6 and 7, 2013:
- Unit 2C washroom #1 and washroom #3
- Unit 3W washroom #4 toilet room
- Unit 3C washroom #2 toilet room
- Unit 6W washroom #4 in the shower room at the toilet
- Unit 7W washroom #1 toilet stall #1
- an identified resident room on 7C [s. 15. (2) (a)]

2. Resident dining room chairs and staff feeder stools were noted to be heavily soiled in the following dining rooms:
- 21 dining room chairs in 2W dining room
- 9 dining room chairs in the 7th floor dining room
- 5 feeder stools in the 4th floor dining room
- 7 dining room chairs in the 3rd floor dining room [s. 15. (2) (a)]

3. Soiled and/or stained cushion surfaces were noted on lounge chairs/sofas in the following resident home areas:
- Unit 3W
- Unit 3C
- Unit 5W
- Unit 6W
- Unit 7W S lounge
- Unit 7C [s. 15. (2) (a)]

4. Soiled privacy curtains with feces and/or other bodily fluids and substances were noted in the following areas of the home:
- Unit 4C washroom #4
- Unit 5C washroom #1 and washroom #2
- Unit 6C washroom #4
- Unit 6W washroom #1 and washroom # 4
- Unit 7W washroom #2 [s. 15. (2) (a)]

5. Wall surfaces were noted to be soiled with dried food, debris and unidentified

substances in the following areas of the home:
- 2nd floor dining room
- Unit 2W outside the "Soiled Linen Chute" and within the "Chapel"
- 4th floor dining room
- 2nd floor dining room dividers on 2C [s. 15. (2) (a)]

6. Textured flooring in the following areas of the home were noted to have dirt and debris build-up:
- Unit 2W
- Unit 2C in shower room #1, and three identified resident rooms
- Unit 3C washroom #1
- Unit 4C washroom #4 in the shower room
- Unit 5C washroom #2 and washroom #3
- Unit 6C three identified resident rooms
- Unit 6W including washroom #2 and one identified resident room
- Unit 7W washroom #2 and washroom #3 in the shower room, one identified resident room
- Unit 7C washroom #1 and washroom #2

The observations were acknowledged by the BSM and staff. [s. 15. (2) (a)]

7. The licensee failed to ensure that the home, its furnishings and equipment are maintained in a safe condition and in a good state of repair.

Damaged wall surfaces were noted in the following areas of the home:
- outside room C315 underneath the wall mounted hand sanitizer and where the handrail was raised leaving holes in the wall below.
- chipped wall tiles in 5C washroom #3 shower room, 2C in the dining room on the east wall, an identified resident room, washroom #2, shower room #2, and 2W an identified shared resident toilet and an another identified resident room. [s. 15. (2) (c)]

8. Damaged flooring with cracks, gouges, stained and/or worn surfaces were noted in the following areas of the home:
- Unit 2W Chapel, lounge, in front of the "Sound Garden" room, within an identified shared resident toilet and another identified resident room
- Unit 2C shower room #1 and shower room # 2
- Unit 4W washroom #4

- Unit 4C washroom #1
- Unit 5C washroom #3 in the shower room [s. 15. (2) (c)]

9. Washroom vanity counters were noted to be damaged/ cracked and/or chipped with some areas noted to have sharp edges exposed in the following washrooms in the home:
- Unit 2C shower room #1, shower room #2, washroom #2, washroom #3 and washroom #6
- Unit 4C washroom #4 in the shower room [s. 15. (2) (c)]

10. Ceiling surfaces were noted to be water damaged with pieces of drywall hanging down and/or bubbled in the following areas of the home:
- Unit 6W washroom #4 in the shower room over the shower stall
- Unit 7W washroom #4
- Unit 7C washroom #1 in toilet stall #1 directly over the toilet. [s. 15. (2) (c)]

11. Missing caulking at the base of resident toilets was noted in rooms 2C shower room #1 and an identified shared resident toilet. [s. 15. (2) (c)]

12. Painted door frames in communal washrooms and shower rooms were noted to be chipped throughout the home. [s. 15. (2) (c)]

13. The servery doors of the 6th floor dining room were noted to be worn and scraped. Additionally, the legs of 41 dining room chairs were observed to be scuffed and worn with no finish left on them. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 10. Elevators
Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the elevators in the home (1, 2, 3 and 4) are equipped to restrict residents access to areas that are not to be accessed by residents. [s. 10. (1)]

Additional Required Actions:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that all the doors leading to stairways and the outside of the home are kept closed and locked.

On May 31, 2013, the following observations were made:
- At 12:15 the door to the main floor stairways #2, #3 and #4 were not locked; all stairways were noted to lead to the basement, a non resident area
- At 12:25 and 12:30, the double doors to the exterior loading dock area were observed open and unattended and did not preclude exit by a resident.

The Administrator was notified of this safety risk and while on tour, the same day, the door to the exterior was found open and unattended again, at 13:12.
The Administrator acknowledged that the expectation is that doors to the exterior are kept locked at all times. [s. 9. (1) 1.]

2. On June 5, 2013 at 12:28 the loading dock exterior doors were observed unlocked and unattended.
A Nutrition Manager acknowledged that the door was open and unattended and closed the door. [s. 9. (1) 1.]

3. The licensee failed to ensure that all doors leading to stairways and the outside of the home are equipped with a door access control system that is kept on at all times.

Doors #2, #3 and #4 leading to stairways and subsequently to the outside of the home are not equipped with a door access control system that is on at all times on the main level of the home. [s. 9. (1) 1. ii.]

4. The licensee failed to ensure that all doors leading to stairways and the outside of the home are equipped with an audible door alarm that allows calls to be canceled only at the point of activation and is connected to the resident/staff communication and response system or 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. [s. 9. (1) 1. iii.]

5. The licensee failed to ensure that any locks on shower rooms are designed and maintained so they can be readily released from the outside in an emergency.

The 2W shower room was noted to have a sliding bolt lock located at the top right corner of the door preventing quick release in the case of an emergency. [s. 9. (1) 3.]

Additional Required Actions:

CO # - 004, 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Findings/Faits saillants :

1. The licensee failed to ensure that the lighting requirements are met.

Lighting levels were noted to be well below the minimum illumination levels in the following areas of the home:
-Unit 2C:
washroom #1- 102 lux
shower room #1- 79 lux
washroom #2- 108 lux
washroom #3- 96 lux
shower room #2 in shower stall- 62 lux
N hallway outside an identified resident room- 80 lux
W hallway outside washroom #4- 54 lux
washroom #4- 54 lux
washroom #6- 96 lux
landing area in front of stairway #3- 57 lux
- Unit 2W
landing area in front of 'Resident Kitchen' on the E side of the dining room- 32 lux
centre of an identified resident room- 38 lux
shared resident toilet for two identified rooms- 202 lux
the hallway outside two identified resident rooms- 38 lux
- Unit 3C
landing area outside stairs- 38 lux
S lounge- 0 lux (light fixtures were not operational at the time of inspection)
hallway between two identified resident rooms- 100 lux
hallway between two identified resident rooms- 19 lux
hallway outside an identified resident room- 54 lux
hallway between two identified resident rooms- 53 lux
hallway outside an identified resident room- 15 lux
hallway between two identified resident rooms- 14 lux
hallway outside washroom #4- 59 lux
landing area in front of 'Tea Room' - 81 lux
landing area in front of 'Balcony' room- 100 lux
- Unit 3W
N-W lounge- 86 lux
hallway between stairway #2 and an identified resident room- 26 lux
hallway outside an identified resident room- 39 lux
hallway outside an identified resident room- 9 lux

hallway between two identified resident rooms- 57 lux
hallway between two identified resident rooms- 37 lux
hallway between two identified resident rooms- 59 lux
hallway outside 'Housekeeping' room- 14 lux
hallway between two identified resident rooms- 85 lux
- Unit 5W
landing area outside stairway #2- 15 lux
hallway outside an identified resident room- 13 lux
hallway outside an identified resident room- 18 lux
hallway between two identified resident rooms- 28 lux
hallway in front of nursing station- 37 lux
- Unit 5C
hallway between stairway #3 and an identified resident room- 90 lux
hallway outside an identified resident room- 11lux
hallway between resident rooms C507-508- 68 lux
hallway between two identified resident rooms- 32 lux
hallway outside 'Housekeeping' room- 19 lux
- Unit 7C
landing area outside stairway #3- 72 lux
hallway between resident rooms C702-703- 44 lux
S lounge- 41 lux
hallway between two identified resident rooms- 34 lux
hallway outside 'Housekeeping' room- 12 lux
N lounge- 184 lux
hallway outside an identified resident room- 22 lux
landing area in front of elevator #3- 29 lux
- Unit 7W
landing area outside stairway #2- 10 lux [s. 18.]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures are implemented to ensure that the temperature of the water serving all bath tubs, showers and hand basins used by residents does not exceed 49 degrees Celsius.

Water temperatures were noted to exceed 49 degrees Celsius during noted periods of time on June 4 and June 6, 2013 at 11:00, 15:00 and 17:00 on Unit 3W, 3C, 4C, 4W and 6C. [s. 90. (2) (g)]

2. Review of the home's manual water temperatures checks for the past 4 months revealed water temperatures to be recorded at 49 degrees Celsius consistently despite the fact that at the time of the inspection water temperatures were noted to fluctuate throughout the days and were noted to exceed 49 C at different periods of the day including the same times in which the home records temperatures. [s. 90. (2) (g)]

3. The licensee failed to ensure that immediate action was taken to reduce the water temperature when exceeds 49 C.

The inspector completed temperature audits on June 4 and 6, 2013.
On June 4, 2013, water temperatures were noted to exceed 49 degrees Celsius in the following areas of the home:
- Unit 3W
washroom #1 at 11:49- hand basin #2- 53.2C and hand basin #1- 53.1C
washroom #3 at 11:30- hand basin #2- 53.1- 53.4C and at 11:32- hand basin #1- 51.8C
washroom #4 at 11:40- shower water- 52.9-53.2C and at 11:42- hand basin- 53.8C
- Unit 3C
washroom #1 at 12:06- shower - 51.0-51.1C, at 12:08- hand basin #2- 53.6C and hand basin #1- 54.4C
washroom #2 at 12:18- hand basin #1- 50.8C and at 12:16- hand basin #2- 50.6C [s. 90. (2) (h)]

4. On June 6, 2013, water temperatures were noted to exceed 49 degrees Celsius in the following noted areas and time in the home:
- Unit 4C
washroom #1 at 2:54- hand basin #1- 50.5C
washroom #2 at 3:03- toilet room hand basin- 50.2C and communal hand basin #2-

51.1C
washroom #4 at 3:15- communal hand basin #1- 51.1C
- Unit 4W
washroom #4 at 3:29- communal hand basin- 51.6C
- Unit 6C
washroom #4 at 5:25- communal hand basin #2- 50.6C [s. 90. (2) (h)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: 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:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

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:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

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).

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:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to communicate menu items to residents at the lunch meals on May 27 and June 3, 2013.

Staff interviews with two PCAs on 3rd and 6th floor, respectively, revealed that they were not aware of what the food was that they were providing for two residents who they were assisting at lunch meals. A further interview with a Dietary Aide revealed that she was also not aware of all the menu items that were being served at the lunch meal, in the 3rd floor dining room, on June 3, 2013 and in particular the texture modified menu items.
Inspector #142 observed a partial lunch meal on June 5, 2013 and a PCA indicated assisting a resident to eat chicken when it was actually beef.
A Nutrition Manager acknowledged that staff are expected to know what they are feeding residents so that this information can be communicated to the residents. [s. 73. (1) 1.]

2. The licensee has failed to ensure that each resident is provided with assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

On June 3, 2013, in the 3rd floor dining room, resident #372, who requires constant supervision with eating, was not provided the assistance and encouragement that the resident required to safely eat and drink.
The resident sat for 13 minutes and then another 20 minutes with no encouragement or assistance offered during the meal.
A Nutrition Manager indicated that he/she had spoken with the charge nurse who acknowledged that the resident required constant supervision at meals and was not receiving same. [s. 73. (1) 9.]

3. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who require assistance.

On June 3, 2013, at the lunch meal, resident #42 was observed coughing. The resident was observed to be at an unsafe feeding height while being assisted with eating by a PCA.
During a staff interview, the PCA acknowledged that the resident was not being assisted at the proper feeding height and indicated awareness of the proper height when assisting residents. A few minutes later another PCA sat down on the stool to

assist the resident. The PCA also acknowledged that the stool was at an inappropriate height but did not change the height of the chair. The resident did not consume any more of the meal.
On June 5, 2013, at 9:08, resident #28, was observed being fed breakfast in bed. The resident was not at a safe feeding height and was heard gurgling.
An interview with the Registered staff who was feeding the resident revealed that the resident should be fed in an upright position and at eye level. The Registered staff acknowledged that the resident was not at eye level while being assisted with breakfast and that the resident is at high risk of choking and is quite congested.
Inspector #128 inquired if the bed position could be altered and the Registered staff confirmed that it did and raised the bed to a height where the resident was at eye level.
A staff interview with a Nutrition Manager and a RD revealed that staff are expected to be seated as close to a 90 degree angle, as possible. They stated "there are set expectations when assisting a resident and staff are expected to be seated in the feeding chairs which would put them at eye level", noting that the chairs are adjustable.
On June 7, 2013, at 09:05 a PCA was observed assisting resident #41 to eat breakfast in the 3rd floor dining room. The PCA was seated approximately 18 inches above the resident's eye level. MOHLTC intervention was provided related to the resident being at potential choking risk.
The PCA stated "I have no idea" what an appropriate safe position would be for residents who require assistance with eating. " I guess that I should be lower than his chair but I don't know. This chair won't go any lower. Half the chairs we have up here are broken".
On June 7, 2013 at 12:28, two residents were observed being assisted with eating in an unsafe position, in the 3rd floor dining room:
Resident #43 was being assisted by a Registered staff member.
During a staff interview the Registered staff indicated that the resident was not in a safe feeding position and the staff should be at an eye level. After acknowledging that the height was not at eye level, the staff lowered the chair to be at eye level.
Resident #44 was also being assisted at the same table by a PCA.
During a staff interview,it was indicated that the staff should be at eye level. Despite acknowledging that she was not at eye level, she stated that the height of the chair could not be altered. [s. 73. (1) 10.]

4. The licensee has failed to ensure that there are appropriate furnishings and

equipment in resident dining areas, including comfortable dining room chairs, tables at an appropriate height to meet the needs of all residents, and appropriate seating for staff that are assisting residents to eat.

Inspector #124 observed the lunch meal on 3rd floor, on May 27, 2013. It was noted that resident #262 was not seated at a table that was an appropriate height and was eating lunch on his/her lap.
Inspector #128 observed lunch, in the 3rd floor dining room, on June 3, 2013 and noted that the table was too high for resident #262, who was seated in a wheelchair. The resident was seated so low that his/her eyes were level with the edge of the table and the resident could not reach the beverage provided at the lunch meal. The resident was observed attempting to eat the meal on his/her lap.
Resident # 27 was also observed to be seated at a table that was at an inappropriate height to meet resident's needs. The resident was seated in a wheelchair and was seated so low that the chin/mouth reached the edge of the table.
A staff interview with a RD confirmed that the expectation is that residents are provided with tables at an appropriate height to meet their needs and acknowledged that neither resident was at a table that was an appropriate height.
It was also observed and reported by PCAs that a number of the stools and/or "feeding chairs" were unable to adjust in height to allow staff to be at an appropriate height while assisting residents with eating activities. [s. 73. (1) 11.]

5. The licensee has failed to ensure that residents who require assistance with eating or drinking were only served a meal when someone was available to provide them assistance.

On June 3, 2013, at 12:12, in the 3rd floor dining room, two residents, #27 and #42, who required assistance with eating sat with soup and fluids placed in front of them. No assistance was provided by staff for 15 minutes.
On June 5, 2013,in the 3rd floor dining room, resident #27 and #239 were observed, with their breakfast sitting in front of them from 08:38 to 08:46 with nobody at the table to provide the required assistance with eating.
A staff interview with a RD revealed that staff are expected to serve food to residents who require assistance with feeding only when residents are in the dining room and a staff member is ready to assist them. [s. 73. (2) (b)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that
- the seven day and daily menus are communicated to residents
- personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible is provided to residents
- appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs, tables at an appropriate height to meet the needs of all residents, and appropriate seating for staff that are assisting residents to eat are provided
- residents who require assistance with eating or drinking are only served a meal when someone is available to provide them assistance, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or medication cart that is secure and locked.

On June 6, 2013 at 08:45 on 3rd floor, the treatment room door was open and 2 unlocked treatment carts containing topical prescription medications were observed inside of the room. [s. 129. (1) (a)]

2. On June 4, 2013 at 8:56 on 4C unit, the treatment cart was observed locked in hallway between rooms C405 and C404. However, the cart has a push/turn lock which does not require a key to unlock it and does not restrict access to the topical prescription medications available in the cart. [s. 129. (1) (a)]

3. On May 29, 2013 at 16:00, inspector #124 observed that the 3rd floor medication room was unlocked, the medication room door was open and the medication cart for 3W side was also unlocked. At this time, the medication room was unsupervised. This was acknowledged by an identified Registered staff.

On June 4, 2013, at 10:51, inspector #124 observed that the 3rd floor medication room door was open, both medication carts were unlocked and the medication room was unsupervised. [s. 129. (1) (a)]

4. The following observations were noted where drugs were not stored in an area that was secure and locked:
On June 3, 2013 at 07:50, the door to the treatment room on 6W was unlocked. Inside of the room was an unlocked treatment cart with topical prescription medications. There was no registered staff in the area.
On June 9, 2013 at 09:15, 2 treatment carts on 7W which contained topical prescription medications were noted to be unlocked in the treatment room. Upon further inspection it was determined that 1 of the treatments carts did not lock. This was reported to the Nurse Manager.
On June 10, 2013 at 07:55, the door to the treatment room on 7W was unlocked. The room contained 2 unlocked treatment carts with topical prescription medications. This was reported to the Nurse Manager.
On June 11, 2013 at 09:05, the door to treatment room on 6W was unlocked and contained 2 unlocked treatment carts with topical prescription medications. It was reported to the Registered staff who locked the door. [s. 129. (1) (a)]

5. On June 6, 2013 at 11:45 on 7W the medication cart was observed unlocked in the lounge area while the Registered staff was administering medication in the dining room and was not able to observe the medication cart.
Residents and visitors were passing by at that time. [s. 129. (1) (a)]

6. The licensee failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies as demonstrated by the following finding.

On June 4, 2013 at 08:00, inspector #124 observed that there were seven envelopes labeled with resident names, five with money, one containing pictures and one with a watch, stored with medications in the top right hand cupboard of the 3rd floor medication room.
This was acknowledged by an identified Registered staff. [s. 129. (1) (a)]

7. On June 5, 2013 it was noted that the medication cart on 7W side contained one pair of unlabeled eye glasses. [s. 129. (1) (a)]

8. On May 27, 2013 at 14:12, on 7th floor an open and unattended treatment room was observed near the nursing station. Two treatment carts containing topical prescription medications were observed in the unlocked treatment room.
Interview with registered staff indicated that the expectation is for the treatment room to be locked at all times. [s. 129. (1) (a) (ii)]

9. On May 29, 2013 at 16:50, on 3W unit, the inspector observed an unattended medication cart in the hallway outside the dining room. There were 2 packages of crushed medication on the top of the cart.
Staff interview revealed that the expectation is that medications are not to be left unattended. [s. 129. (1) (a) (ii)]

10. The licensee failed to ensure that the controlled substances were not stored in a separate, double locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On May 29, 2013 at 16:00, the controlled substances for 3W were observed to be stored in a separate locked cupboard in an unlocked medication cart in an unlocked medication room and the medication room door was open.

On June 4, 2013 at 10:51, the controlled substances for the 3C and 3W units were observed to be stored in locked stationary cupboards of unlocked medication carts in an unlocked medication room. The door to the medication room was open. [s. 129. (1) (b)]

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On June 3, 2013 at 09:00, inspector #153 requested access to the 6W medication room and the door was opened by the nursing clerk who had the keys to the medication room on a lanyard around her neck. In the medication room are stored regular and controlled substances. The nursing clerk does not dispense, prescribe or administer medications in the home.
On June 4, 2013 at 10:50 the nursing clerk from the main floor was observed to transport the discontinued drugs to the Central Supply Room in the basement and unlock with a key to the medication room where the stock medications are stored along with the surplus drugs waiting for destruction. The nursing clerk does not dispense, prescribe or administer medications in the home. [s. 130. 2.]

2. On June 5, 2013 it was observed and confirmed by the Registered staff on 5th and 7th floor that the key for the treatment room is the same key used for the linen chute. The key is kept in the nursing station on the wall and PCAs are using it to get access to the linen chute and to continence care products. The treatment carts contain prescribed topical medications and are kept unlocked in the treatment room when not in use. [s. 130. 2.]

Additional Required Actions:

CO # - 010 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #9: 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:
5. Every resident has the right to live in a safe and clean environment. 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the residents' right to be treated with courtesy and respect and in a way that fully recognizes the residents' individuality and respects residents' dignity was fully promoted and respected.

Resident #424 indicated to the inspector that staff do not provide care in the mornings in a respectful and dignified manner. The resident reported that staff do not introduce themselves or inform the resident of the care to be provided. The resident indicated the PCAs pull off the covers while the resident is asleep. This makes the resident feel disrespected and treated as an object, not a human being. [s. 3. (1) 1.]

2. During the lunch meal on May 27, 2013, at approximately 12:35, inspector #124 asked a specified staff member to identify a resident. The staff member left one table and approached resident #37 from behind, folded down the collar of the resident's shirt to read the clothing label. During this time, the staff member did not speak to the resident. When the staff member touched the resident's collar, the resident startled and made a sound. Then resident #38 called for help and an other identified staff member responded from across the dining room with "Wait! Wait!" spoken in a loud voice.

On June 11, 2013, during a discussion with inspector #124, the Nurse Manager stated that the expectation was that staff would approach residents from the front and speak with them prior to touching them. [s. 3. (1) 1.]

3. June 6, 2013 at 08:45 a staff member was observed feeding residents in the 3rd floor dining room and while the staff member was feeding residents, he was noted to be speaking in a loud tone to other staff members about news related stories and television programs. [s. 3. (1) 1.]

4. The licensee failed to ensure that every resident has the right to live in a safe and clean environment.

Clean linen carts were noted to be stored in front of hand basins in communal washroom #3 on unit 5C obstructing resident access to wash their hands after using the washroom. [s. 3. (1) 5.]

5. The licensee failed to ensure that every resident has the right to be afforded privacy and treatment and in caring for his or her personal needs.

The curtain for the toilet in washroom #4 on 5C unit is not wide enough to ensure privacy for residents when they use the toilet.
Observation and interview with Resident #119 indicated that the toilet curtain from the washroom #4 it is not wide enough to ensure privacy for the resident while using the toilet. The resident avoids using the toilet with the curtain because the resident feels exposed. [s. 3. (1) 8.]

6. On June 10, 2013, at 11:35 on 4C unit, in the hallway near washroom #2 a PCA was observed shaving a male resident. [s. 3. (1) 8.]

7. On June 6, 2013 at 08:05, on 7th floor, a Registered staff was observed completing glucose monitoring for resident #26, in the lounge while other residents were present. On June 10, 2013 at 09:15, on 3rd floor, resident #29 was observed receiving inhalation treatment from a Registered staff, in the lounge while other residents were present.
A Nurse Manager indicated that the expectation is that residents are to be afforded privacy while receiving treatments. [s. 3. (1) 8.]

8. On June 7, 2013, at 9:30, on 7th floor, an identified registered staff was observed administering Insulin injection to resident #1 in the TV area. Residents, volunteers and visitors were in the TV area at that time. [s. 3. (1) 8.]

9. The licensee failed to ensure that residents' right to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004, are kept confidential in accordance with that Act.

On June 7, 2013 at 8:29, on 7th floor, the inspector observed two Medication Administration Records(MAR) left open on the 7C medication cart in the TV area. Residents' personal health information was easily available for other individuals to view. Visitors and volunteers were passing by at that time. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that
- every resident is treated with courtesy and respect and in a way that fully recognizes the residents' individuality and respects the residents' dignity
- every resident is afforded privacy and treatment and in caring for his or her personal needs, to be implemented voluntarily.

WN #10: 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).

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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care set out clear directions to staff and others who provide direct care to resident as follows.

The current written plan of care reviewed on March 21, 2013 indicates that resident #425 lost all natural teeth. No mouth care required in the plan of care.
Resident observation and staff interviews revealed that resident has all natural teeth except the wisdom teeth and requires mouth care as the resident is not able to perform it. [s. 6. (1) (c)]

2. The written plan of care for resident #186 indicated in the Master Profile under the communication section the resident wears glasses and can see fine print. Through interviews with staff it was revealed the resident does not wear eyeglasses and is unable to read fine print. [s. 6. (1) (c)]

3. The written plan of care for resident #138 dated April 20, 2013 identified that the resident has impaired visual function and does not wear glasses.
Resident #138's Master Profile dated April 20, 2013 identified that the resident's vision was highly impaired and that the resident wears glasses.
An identified Registered staff reported to the inspector that the resident has not worn glasses for some time because the resident started taking them off, so family took the glasses home. [s. 6. (1) (c)]

4. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.
The current plan of care for resident #27 indicates that the diet order was changed to a minced texture on May 13, 2013.
The resident was observed to receive a regular texture lunch meal in the 3rd floor dining room on June 3, 2013.
A RD indicated during an interview that the expectation is that the correct diet order is provided to each resident at time of meal service. [s. 6. (7)]

5. The licensee failed to 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.

A review of the health record for resident #27 revealed that a nutrition and hydration care plan is not available to guide staff in providing care to the resident and

specifically related to the amount of assistance with eating required by the resident.
An identified Registered staff was interviewed and indicated that the nutrition and hydration care plan is located on the computer and the direct care staff do not have access to the computer.
The Nurse Manager acknowledged the expectation was that the care plan should be available on the chart so that staff can have convenient and immediate access to the information. [s. 6. (8)]

6. The licensee shall ensure that the provision of care set out in the plan of care is documented.

On June 3, 2013, at approximately 11:20, an identified Registered staff reported to inspector #124 that she had not yet signed for the 08:00 medications that had been administered. There were no initials to indicate that residents had received their 08:00 medications. The specified Registered staff confirmed that residents #39, #40 and #45 had received their medication but because two residents required showers before breakfast, she did not have time to sign that the medication had been given. [s. 6. (9) 1.]

7. On June 11, 2013 at 09:15, on 6W, a review of the Medication Administration Record for resident # 372 revealed the 08:00 medications had not been recorded as given.
When interviewed, the Registered staff indicated the medications had been administered but had not been recorded as given because she ran out of time as a result of the home being without hot water for morning care.
Nurse Manager indicated when interviewed the expectation is that the medications will be recorded as administered following the resident swallowing the medication. [s. 6. (9) 1.]

8. Mouth care for resident #425 is identified in the plan of care, but interviewed staff indicated that it is not documented. [s. 6. (9) 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
- the written plans of care sets out clear directions to staff and others who provide direct care to residents
- the care set out in the plan of care is provided to residents as specified in their plans
- 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
- the provision of care set out in the plan of care is documented, to be implemented voluntarily.

WN #11: 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 :

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1. The Long Term Care Homes Act, 2007, s.11 requires that the licensee ensure there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of residents.
The licensee failed to ensure that any plan, policy, protocol procedure, strategy or system instituted or otherwise put in place is complied with as follows.

A review of policy # RC-0523-17, titled Assistance at Mealtime, dated June 15, 2010 and policy # FN-0315-00, titled Plating Meals in the Dining Room , dated July 1, 2010 revealed that these policies were not being complied with . The policies indicated that the care team was expected to "offer choice of meal verbally and by presentation of sample plate" and ensure "choice of entrée, vegetable and dessert".
Each resident was not offered alternative choices of entrees, vegetables and desserts nor beverages as per the planned menu, at meals observed throughout the inspection.
Choice was not provided to all residents, on May 27, 2013 as evidenced by the following observations:
Inspector #128 did not observe choice of beverages, entrée or vegetables offered in the 6th floor dining room and inspector #142 did not observe choice of entrée or vegetables offered in the 4th floor dining room.
Additionally, inspector #128 observed 15 residents, in the 3rd floor dining room, on June 3, 2013, not being offered a choice of beverages, entrée or vegetables and dessert.
A Nutrition Manager and a RD confirmed that the home's expectation is that residents must be offered choice of beverages, entrée, vegetable and dessert at lunch and dinner meals. [s. 8. (1)]

2. A review of policy # RC-0523-17, titled Assistance at Mealtime, dated June 15, 2010 also revealed that it is not being complied with in relation to the following;
- The policy states "throughout the meal, monitor intake and offer other choices as appropriate". On May 27, June 3 and June 5, 2013 inspectors #124, #128 and #142 did not observe residents who were not consuming their meals offered other choices of menu and/or preferred food and beverage items.
- The policy indicated "use long handled teaspoon for providing feeding assistance to residents on pureed and minced diets unless otherwise indicated on plan of care". The policy was not followed as residents were observed to be fed by staff using tablespoons.
In an interview held with a RD, to identify potential choking risks, she revealed that all

staff who are assisting residents with eating are "expected to use parfait spoons so that there isn't too much food put into the oral cavity at one time".
On June 6, 2013 three residents were observed being assisted, by two Registered staff, at the 3rd floor lunch meal using tablespoons.
One of the Registered staff who was assisting 2 of the residents acknowledged that the spoon used should have been a parfait spoon but she stated that they didn't have enough parfait spoons available. [s. 8. (1)]

3. The Ontario Regulations 79/10 s. 114(1) requires that the licensee develops an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.
The licensee failed to ensure that any plan, policy, protocol procedure, strategy or system instituted or otherwise put in place is complied with as follows.

The home's policy titled Expiry and Dating of Medications # 5-1, dated February 2012, indicates under procedure items 1 and 2;
1) Examine the expiry date of all medications on a regular basis. Be especially careful to check all storage areas for extra medication, PRN medications, Government stock, topicals and eye drops.
2) Remove any expired medications from stock and order replacement if necessary.
The policy was not complied with in the following situations.

On June 3, 2013, the medication carts on 7th floor were observed. It was noted that numerous medications were expired but still in the cart. The Registered staff was informed.
Lorazepam 0.5mg 3 tablets- expired March, 2013
Dorzolamid/Tymolol eye drops - expired April 30,2013
Combigan ophtalmic solution - expired May 31, 2013
Isopto tears- expired April 30, 2013
Tylenol 325mg, 30 tablets- expired May, 2013
ASA 325mg,approximately 500 tablets- expired May, 2013
Baxedin 0.05%- chlorhexadine- expired January, 2013
On June 4, 2013 at 10:50, inspector #153 observed the following expired medications in the stock medication room located in the basement in the Central Supply Room.
The following expired medications were noted on the shelf and it was communicated to staff;
5 bottles of Mucillium- expired March, 2013

9 bottles of Ferrous Sulphate 300mg - expired January, 2013
1 bottle of Iron Supplement 300mg- expired June, 2011 [s. 8. (1)]

4. A review of the policy titled Destruction of discontinued narcotics and controlled medications, PH-0231-00, dated January 6, 2012 indicates to remove all discontinued narcotics and controlled medications from dispensing bin on the same shift as the drug is discontinued. The policy was not complied with in the following situations;

On June 3, 2013 it was observed in the medication cart for 7th floor discontinued narcotics kept in the narcotic bin in the medication cart until disposal as per Registered staff statement, as follows;
Oxycocet 5mg/Acetaminophen 325mg, 7 tablets, discontinued on May 22,2013, and
~~Bethahistine- 39 tablets, discontinued on May 2,2013.~~
The Registered staff indicated that the discontinued narcotics are being kept in the narcotic bin in the medication cart until the Nurse Manager and the pharmacy are removing them for destruction. [s. 8. (1)]

5. The Long Term Care Homes Act, 2007, s.11 requires that the licensee ensure there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of residents.
The licensee failed to ensure that any plan, policy, protocol procedure, strategy or system instituted or otherwise put in place is complied with as follows.

A review of policy #FN-0202-00, titled Meal Acceptability, dated July 1, 2010 revealed that there are three Food Quality Audits and Questionnaires, related to this policy. The purpose of the audits is to "monitor overall acceptability, plate returns and specific comments at meal rounds". One of the audits, entitled Plate Waste Log is used to identify the amount of food left on residents plates in dining rooms and the reason for the waste.
Throughout the course of the inspection, plate waste was observed in dining rooms and residents expressed concerns related to food quality.
On 6th floor, May 27, 2013 at the lunch meal, numerous plates were observed not consumed and 25 residents had left 3/4 or greater of their food uneaten.
On 3rd, floor, June 6, 2013, at the lunch meal, numerous plates were observed not consumed and 16 of those plates had 3/4 or greater food left on them.
A staff interview with a Nutrition Manager revealed that the plate waste audit is not being completed as per the expectation in the policy. [s. 8. (1)]

6. The licensee failed to ensure that any policy put in place is in compliance with all applicable requirements under the act.

A review of policy #RC-0523-02, titled Guidelines for Dining Room Service, dated March 3, 2008 states "ensure each resident waits no more than 5 minutes for assistance to eat (if required) once the meal is served".
A RD acknowledged that the policy is not in compliance with the Regulations and needs to be updated. [s. 8. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any policies put in place in the home are in accordance with all applicable requirements under the Act and are complied with, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times.

On May 28,2013 at 10:00 the bed side call bell in resident room 504W was not functioning, and the 2 toilet call bells in the washroom #1 had no sound. [s. 17. (1) (b)]

2. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

There is no resident-staff communication and response system in unit 2C in the lounge and dining room, areas accessible to residents. [s. 17. (1) (e)]

3. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that clearly indicates when activated where the signal is coming from.

On June 11, 2013, the inspector activated the call station in unit 2W dining room. PCAs were observed to look for the activated call station but did not know where the call was coming from. At the nursing station, the display was coded with numbers for the call without a chart to interpret the location of the call. [s. 17. (1) (f)]

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 is equipped with a resident-staff communication and response system that
- is on at all times
- is available in every area accessible by residents, and
- clearly indicates when activated where the signal is coming from, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a RD who is a member of the staff of the home completes a nutritional assessment for all residents whenever there is a significant change in the resident's health condition.

A review of the clinical record for resident #262, on June 7, 2013, revealed that a nutritional assessment has not been completed by the RD despite the resident experiencing nutrition and hydration risks and a change in the resident's condition. A RD made a note on the resident's progress notes, August 17, 2012 which stated: "Resident not doing well. Appetite changing. Staff encourage intake -offer supplement only small amount taken –palliative".
A dietary referral was made out by nursing staff on January 17, 2013 that stated palliative care. An assessment was not completed and both the original and the carbon copy were still on the chart on June 7, 2013.
In a staff interview with a RD she stated that an assessment had not been completed at that time of the referral because she was already aware that the resident was palliative. The RD acknowledged that she would assess the resident that day. [s. 26. (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 a RD who is a member of the staff of the home completes a nutritional assessment for all residents whenever there is a significant change in the resident's health condition, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.

A review of the clinical record for resident #262, on June 7, 2013, revealed that weight changes have not been assessed for this resident. The resident currently weighs 36.4 kg and is at 68.9% of the low end of the usual/ideal weight. The home's Nutrition and Hydration Risk tool identifies that any resident under 69% Ideal Body Weight (IBW)/ Goal Weight (BMI less than 19) is considered to be severely underweight. Quarterly assessments completed on two identified dates revealed that the resident was at 62.5% and 63.8% of his/her IBW, respectively, but those assessments did not indicate that the resident was at high nutritional risk. Additionally, there is no documented evidence to support that a referral was made to the RD related to the weight loss. A RD confirmed that referrals were not sent in either quarter and they should have been so that the severely underweight resident could have been re-assessed. The RD acknowledged that the resident was at high risk related to unplanned weight change and stated that she would do an assessment of the resident that day. [s. 69.]

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 residents with weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #15: 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 failed to ensure that planned menu items were offered and available to all residents at meals.

On June 3, 2013, on 3rd floor it was noted that 5 of 6 portion sizes were not served as per the planned menu.
The following scoop sizes/portion sizes were used vs. what the planned menu stated should be used:
- pureed beef - 3 oz spoodle - should have been pureed wiener #10 scoop;
- minced stew - 4 oz spoodle - should have been minced wiener #10 scoop;
- pureed vegetables - 3 oz spoodle - should have been #10 scoop;
- turkey a la king - 4oz spoodle - should have been #6 scoop; and
- pureed turkey a la king - #12 green scoop -should have been #6 scoop.

A Dietary Aide verified the portion sizes above.
A Nutrition Manager stated that spoodles are not to be used for either a #12 scoop or a #10 scoop.
The RD confirmed that the expectation is that the planned menu is followed at all times.
Five residents were reviewed for fluid intake as per the planned menu at the lunch meal, on 3rd floor, June 3, 2013. None of the five residents (0%) were offered the 250 ml of water on the planned menu. Only two of the five residents (40%) were offered 200 ml coffee/tea as per the planned menu.
A RD acknowledged that all residents are to be offered 250ml water at every meal. Additionally, 125 – 250 ml milk, depending on the meal, and 200 ml coffee or tea is to be offered unless the resident doesn't want it or it is otherwise indicated on their care plan.
It was observed at the lunch meal, on 3rd floor, on June 3, 2013, that residents on a pureed texture were not offered pureed bread as per the planned menu. Menu items were reviewed with a Dietary Aide at the end of the meal and it was noted that none of the pureed bread had been served. The Dietary Aide stated that they had served mashed potatoes instead of the pureed bread. The planned menu did not have mashed potatoes on it.
On June 6, 2013, at the lunch meal, on 3rd floor, it was noted by inspector #124 that 4/4 residents on a puree texture diet were not offered pureed bread as per the planned menu despite this previously being brought to the attention of the home earlier in the week. [s. 71. (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 planned menu items were offered and available to all residents at meals, to be implemented voluntarily.

WN #16: 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,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).**

**s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).**

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system provided for standardized recipes for all menu items.

Standardized recipes were reviewed in the kitchen with 2 Cooks and a Nutrition Manager on June 3, 2013. The standardized recipes for the lunch menu on June 3, 2013 revealed that there were no recipes to guide staff in the preparation of the minced and pureed wieners on the menu for Monday, Week #2.
Both Cooks acknowledged that the recipes were not available for the texture modified wieners.
Additionally, it was determined after a staff interview with a Cook that the standardized recipe was not followed for the preparation of the pureed bread. The Cook indicated that the amount of water added to the bread was not measured and the syrup required by the recipe was not added as the Cook did not want the bread to be too sweet.
The bread on the pureed texture menu indicates that it is to be slurred bread. However, the recipe states "blend until smooth consistency" which is not in keeping with "slurred bread".
An interview with a RD revealed that the home historically used a flour product to make "slurred bread". However, this was discontinued and she indicated that this was an oversight and the terminology should have been changed on the menu, as well as the recipe, to reflect " pureed bread" terminology.
A Nutrition Manager and the Assistant Administrator acknowledged that the expectation is that standardized recipes are available and followed. [s. 72. (2) (c)]

2. The licensee failed to ensure that the food production system provide for the preparation of all menu items according to the planned menu.

Observation of the lunch meal on 3rd floor, June 3, 2013 revealed that residents on texture modified diets were not provided with the same food items that were on the planned menu. Hot dogs were on the menu but residents on minced and pureed diets were not provided with the minced and pureed wieners that were on the planned menu. The pureed mixed vegetables were not prepared as per the planned menu. Staff interviews, in the kitchen, with 2 Cooks revealed that they did not follow the planned menu for the lunch meal, June 3, 2013. A Nutrition Manager was also present during the interviews. One Cook stated they used frozen carrots, cauliflower and some beans and put that together instead of pureeing the mixed vegetables of corn, peas, carrots and green beans which was on the menu. This was reported to be done

because they had part cases of the individual vegetables in the freezer. Another Cook stated he/she had prepared the minced and pureed wieners but when inspector #128 stated that this was not what was in the 3rd floor dining room, the Cook acknowledged that something else was prepared. Inspector #128 stated that it had carrots in it. The inspector informed the Cook and Nutrition Manager that when it was tasted in the servery, by the inspector, it tasted like beef stew. The Cook stated that they did not serve beef stew in the home. The cook acknowledged that it might have been the leftover spaghetti and meat sauce from the meal served on Saturday, June 1, 2013 that was used but he/she did not remember putting carrots in it. The Cook was unaware of what food product had been served to the residents.
Samples that were saved for Public Health revealed that it looked like minced beef stew. A Nutrition Manager was unable to identify the food item served indicating that it tasted like beef stew.
A RD and the Acting Assistant Administrator acknowledged that the expectation is that all menu items are prepared according to the planned menu. [s. 72. (2) (d)]

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 food production system provides for
- standardized recipes available for all menu items, and
- preparation of all menu items are according to the planned menu, to be implemented voluntarily.

WN #17: 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 failed to ensure that all hazardous substances at the home are labeled properly and are kept inaccessible to residents at all times.

An unattended housekeeping cart containing hazardous chemicals, including QC91 Bathroom Cleaner, was observed open and unattended on the 7th floor near room #15, on May 31, 2013 at 10:22.
Housekeeping Aides stated the expectation is that the carts are locked when unattended.
One of the housekeeping staff stated that the rolled top protective cover was broken and so was the lock on the door on one side of the cart, and indicated that a requisition would be submitted for the cart to be repaired.
An interview with the Administrator, on May 31, 2013 at 10:40 revealed that the home's expectation is that staff keep housekeeping carts with them and that they are locked at all times. [s. 91.]

2. Observation of the door to the main floor stairways #3, on May 31, 2013, revealed that it was not secured and led to the basement. A tour was initiated at 12:15 and the following risks related to hazardous substances were revealed:
- an unattended and unlocked housekeeping cart was observed at 12:18 in the old generator room area which contained Profi floor cleaner/oil and grease remover
- an unattended and unlocked housekeeping cart was observed at 12:23 in the soiled linen holding area which contained A-456 Neutral Detergent Disinfectant Fungicide and Virucide; a bottle of PerCept RTU Virucide Disinfectant was observed in the same area
- 2 unattended and unlocked housekeeping carts were found in the storage room at 12:32 which contained QC 91 Neutral Disinfectant Cleaner, as well as an unlabeled spray bottle containing an unidentified liquid which stated Do Not Drink.
These safety risks were brought to the attention of the Administrator. While on tour with her, the same hazardous chemicals were found in the old generator room at 13:08 and the soiled linen room at 13:10.
Additionally, AltroFix 25 and Fast Concrete Repair were observed, in the basement, next to the loading dock.
The Administrator acknowledged that the expectation is that chemicals should not have been accessible to residents. [s. 91.]

3. Windex multi surface cleaner was observed in the Korean kitchen on 3rd floor on June 5, 2013 at 11:40.

The registered staff on the unit stated that this was a hazardous substance and should not be accessible to residents. [s. 91.]

Additional Required Actions:

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

WN #18: 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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours. O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director is informed no later than one business day after the occurrence of an injury in respect of which a person is taken to hospital

Resident #372 fell, sustained a fracture and was taken to the hospital. The Director was informed three business days later. [s. 107. (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 the Director is informed no later than one business day after the occurrence of an injury in respect of which a person is taken to hospital, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug is administered to a resident in the home unless the drug has been prescribed for the resident.

Resident #9 received Humalog Lispro 15 units on June 3, 2013 at 07:30.
A review of the physician orders identified an order for Humalog Lispro 5 units at breakfast and dinner and 8 units at lunch.
When interviewed the registered staff member indicated resident #9 was given Humalog Lispro 15 units as directed by the sliding scale handwritten on the MAR for the period May 25 - June 24, 2013.
The sliding scale directed staff to administer 15 units for a glucose level of 30.
A review of the physician orders failed to locate a current physician order for the sliding scale dosages.
When interviewed the registered staff and the physician confirmed there was not a current order for the sliding scale dosages.
That same day, the physician wrote an order for the sliding scale and Registered staff completed a medication error incident form. [s. 131. (1)]

2. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Resident #30 had a physician's order for Tramadol ER 300mg by mouth at 08:00 each day.
On June 4, 2013 at approximately 11:00, resident #30's 08:00 dose of Tramadol ER 300mg was discovered in the narcotic box.
An identified Registered staff acknowledged that resident #30 did not receive Tramadol ER 300mg at the correct time and that this was a medication error. [s. 131. (2)]

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;
- no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident
- drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On May 27, 2013 at 12:09 in the 6th floor dining room the inspector observed three volunteers serving rice to residents on side plates from a side table outside the dining room. One volunteer was observed serving rice to residents using chop sticks and touching residents' plates with her fingers and then moving on to serve the next resident without any hand washing/hand hygiene in-between.
At the same meal a PCA was observed running fingers through his/her hair and then feeding a resident without hand washing/hand hygiene before assisting the resident. [s. 229. (4)]

2. On June 3, 2013 at 08:00 the inspector observed a PCA exit a resident room on 6W wearing gloves, proceed to the shower room and touch the curtain, then remove gloves without using hand sanitizer and then entered into another resident's room to provide care.
Another PCA was observed wearing gloves when brushing a resident's hair then proceeded to clean linen cart, removed clean linen with the same gloves and went into the shower room to provide care. [s. 229. (4)]

3. On June 5, 2013 at 11:15 an identified housekeeping staff was observed on 5th floor performing hand hygiene with one glove on, removing the dirty glove after that and placing it in the pocket where the staff was keeping clean gloves. The staff did not perform hand hygiene after removing the used glove. [s. 229. (4)]

4. On June 4, 2013, a PCA on 3W was observed to wheel a resident out of washroom #4 following care wearing the same gloves used to conduct care. Removal of gloves or hand washing was not observed to be completed prior to assisting the resident. [s. 229. (4)]

5. On May 27, 2013, the inspector observed an unlabeled bedpan sitting on the floor in residents' bathroom on 4th floor (bathroom 1).
On May 30, 2013, the inspector observed in 4C tub room unlabeled containers of Vaseline, barrier cream, and shaving cream in a basket in the cupboard.
On June 10, 2013, the inspector observed open and unlabeled zinc and Vaseline jars in residents' 4th floor shower room #2. [s. 229. (4)]

6. On June 6, 2013 at 12:00 medication pass on 7th floor, three identified registered staff were observed administering medication without performing hand hygiene between residents.
An identified registered staff was observed to use the hand sanitizer and wipe off the excess hand sanitizer with napkins.
On June 7, 2013 at 8:00 medication pass on 7th floor, four identified registered staff were observed administering medication without performing hand hygiene.
An identified registered staff was observed wearing gloves without performing hand hygiene before or after removing the gloves. [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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents.
On May 27, 2013 at 14:00, on 6th floor, the inspector observed a wet spill on the floor near washroom #4 and no signage of "wet floor" in the area was observed. [s. 5.]

2. On May 27, 2013 at 13:45 the inspector observed approximately a 4 inch gap in flooring that is a potential tripping hazard on 6th floor. It was reported to the Administrator who stated that the expectation is that the unit staff on the floor and/or the nurse manager as well as maintenance would be responsible for monitoring it. [s. 5.]

3. On May 29, 2013 at 15:30 the inspector informed the Administrator about the potential tripping hazard noted in the main entrance. The flooring is damaged and is uneven. Writer previously tripped on the ledge in this area.
The Administrator was not aware of the trip hazard and nobody had previously reported this hazard to her. [s. 5.]

4. Wires were noted to be on the floor in front of resident lounge chair in room C510 at bed A creating a potential trip hazard. [s. 5.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee failed to ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

Three identified rooms are bedrooms that are occupied by two residents.
- On May 28, 2013 and June 5, 2013, it was observed that resident #138 and resident #262 had insufficient privacy curtains to provide privacy.
On June 5, 2013 the BSM confirmed that resident #138 in room C316 and resident #262 in W316 had insufficient privacy curtains to provide privacy.
- On June 4, 2013 inspector #101 observed that an identified room was missing a privacy curtain.
On June 5, 2013, the BSM acknowledged that on June 4, 2013 the privacy curtain was removed for laundering and a replacement curtain was not hung while the original curtain was being laundered. [s. 13.]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

On May 27, 2013 the temperature of lounge area on 7th floor near room 716 was 11.5 degrees Celsius. Four residents in the area were wearing jackets and expressed concerns about the temperature in the home being cold.
The temperature of the following rooms was taken:
room 717- 18.3 C
room 718- 15.2 C-resident observed in bed with blankets over his head
room 709- 17.6 C
lounge near room 706- 17.6 C
room 706 - 20.6 C - one resident and a visitor expressed concerns about being cold.
[s. 21.]

2. Staff interview with Assistant Administrator and the Administrator related to low air temperatures noted in the home indicated that the temperature was lowered intentionally to prevent the heat from coming in as the outside temperature was expected to rise the following day.
They indicated of not being aware of any residents' concerns related to cold temperatures in the home. As a result the heat was turned back on.
The nurses will monitor the temperature throughout the evening and night and turn up thermostats as required. [s. 21.]

3. On May 28, 2013 at 16:23 resident #407 on 7C unit complained of being cold and indicated using a heating pad to keep warm. [s. 21.]

4. Air temperatures on June 4, 2013 were noted to be maintained below 22 degrees Celsius on the C wing of the home. The following areas were noted:
- Unit 3C outside resident room C302- 21.4C
- Unit 5C outside resident room C502- 20.8C, S lounge- 17.5C, outside resident room C513 at the threshold- 19.1C and within resident room C513- 20.8C. [s. 21.]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that for the home's Restorative Care program there is a written description of the program that includes its:
- goals and objectives
- relevant policies, procedures, protocols
- methods to reduce risk and monitor outcomes, and
- protocols for referral of residents to specialized resources where required
This was confirmed in interviews with the program's lead and the DON. [s. 30. (1) 1.]

2. The licensee failed to ensure that the home's restorative care program is evaluated and updated annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
The DON acknowledged that the Restorative Care program is not evaluated annually. [s. 30. (1) 3.]

WN #25: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure a response in writing within 10 days of receiving Family Council's advice, concerns or recommendations.

On June 4, 2013 an interview with the Family Council representative and a review of the Family Council minutes, revealed that concerns, including the following issues, had been identified in the months of January, February, March and April 2013:
- staff talking to each other and not in English in front of residents
- staff not wearing name tags
- broken blinds on 4th floor (identified 3 times), and
- residents smoking in inappropriate locations.

Despite concerns being identified in writing, there was no documentation to support that a written response was provided to the Family Council.
An interview with the Administrator revealed that she attends every meeting, at the request of Family Council, so she responds to them at the next meeting. She was unaware that the home was required to respond, in writing, within 10 days of concerns or recommendations being made. [s. 60. (2)]

WN #26: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the package of information includes at a minimum the following information:
- the home's policy to promote zero tolerance of abuse and neglect of residents [s. 78. (2) (c)]

2. - how to obtain a copy of the policy to minimize restraining of residents [s. 78. (2) (g)]

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

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee failed to document and make available to the Family Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

A review of the Family Council minutes and an interview with a Family Council representative revealed that the results of the satisfaction survey were not shared with the Family Council.
The Administrator acknowledged that the results of the satisfaction survey have not been shared with Family Council. [s. 85. (4) (a)]

2. The licensee failed to ensure that the documentation required by clauses (a) and (b) were made available to residents and their families.
This information was confirmed by the home's Administrator and the DON. [s. 85. (4) (c)]

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented for addressing lingering, offensive odours when noted in 2W unit at the entrance on June 4 and 6, 2013. [s. 87. (2) (d)]

WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following:

s. 241. (3) The licensee shall keep petty cash trust money in the home, composed of money withdrawn from a trust account, that is sufficient to meet the daily cash needs of the residents who have money deposited in a trust account on their behalf. O. Reg. 79/10, s.241 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is petty cash trust money in the home, composed of money withdrawn from a trust account, that is sufficient to meet the daily cash needs of the residents who have money deposited in a trust account on their behalf.

Three residents, with trust accounts, were interviewed and indicated that they are only able to access their money on Mondays, Wednesdays and Fridays between the hours of 11:00 and 11:30 and not on Tuesdays, Thursdays or the weekends.
The resident banking policy Asset Management Section 03 indicates that formal banking services shall be provided at a designated location at a minimum of 3 times per week and that ad hoc banking services shall be provided to residents, including visiting the units, as required.
The three residents interviewed were not aware that banking services were available beyond the designated times.
The Support Assistant (Finance) and Acting Administrator acknowledged that residents do not have access to petty cash trust money on the weekends. [s. 241. (3)]

**THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:**

**COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2013_103193_0002	193
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #001	2011_097101_0005	193

Issued on this 24th day of July, 2013

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MONICA NOURI (193), AMANDA WILLIAMS (101), JANET MCPARLAND (142), LYNDA HAMILTON (124), LYNN PARSONS (153), RUTH HILDEBRAND (128)
Inspection No. / No de l'inspection :	2013_103193_0008
Log No. / Registre no:	T-204-13
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 5, 2013
Licensee / Titulaire de permis :	TORONTO LONG-TERM CARE HOMES AND SERVICES 55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	CASTLEVIEW WYCHWOOD TOWERS 351 CHRISTIE STREET, TORONTO, ON, M6G-3C3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nancy Lew

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To TORONTO LONG-TERM CARE HOMES AND SERVICES, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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

Order / Ordre :

The licensee shall ensure that the home, furnishings, walls and floor surfaces are maintained clean and sanitary. This includes resident lounge chairs, dining room chairs, walls, flooring, privacy curtains and call bell strings.
The home's cleaning routines and frequencies are to be reviewed to ensure surfaces are maintained clean and sanitary on an ongoing basis.

Grounds / Motifs :

1. Textured flooring in the following areas of the home were noted to have dirt and debris build-up:
- Unit 2W
- Unit 2C in shower room #1, and three identified resident rooms on 2C
- Unit 3C washroom #1
- Unit 4C washroom #4 in the shower room
- Unit 5C washroom #2 and washroom #3
- Unit 6C resident rooms C601, C613, C620
- Unit 6W including washroom #2 and resident room W602
- Unit 7W washroom # 2 and washroom #3 in the shower room, resident room W704
- Unit 7C washroom #1 and washroom #2 (101)

2. Wall surfaces were noted to be soiled with dried food, debris and unidentified substances in the following areas of the home:

- 2nd floor dining room
- 2W outside the 'Soiled Linen Chute' and within the Chapel
- 4th floor dining room
- 2nd floor dining room dividers on 2C (101)

3. Soiled privacy curtains with feces and/or other bodily fluids and substances were noted in the following areas of the home:
- Unit 4C washroom #4
- Unit 5C washroom #1 and washroom #2
- Unit 6C washroom #4
- Unit 6W washroom #1 and washroom # 4
- Unit 7W washroom #2

(101)

4. Soiled and/or stained cushion surfaces were noted on lounge chairs/sofas in the following resident home areas:
- Unit 3W outside room W302
- Unit 3C outside room C313 and in the S lounge
- Unit 5W outside room W504 and the lounge area outside the dining room
- Unit 6W outside rooms W602 and W613
- Unit 7W lounge
- Unit 7C outside room C702 , C708 and within room C716 (101)

5. Resident dining room chairs and staff feeder stools were noted to be heavily soiled in the following dining rooms:
- 21 dining room chairs in 2W dining room
- 9 dining room chairs in the 7th floor dining room
- 5 feeder stools in the 4th floor dining room
- 7 dining room chairs in the 3rd floor dining room (101)

6. Call bell strings were noted to be soiled with feces and other substances in the following areas of the home on June 6 and 7, 2013:
- 2C washroom #1 and washroom #3
- 3W washroom #4 toilet room
- 3C washroom #2 toilet room
- 6W washroom #4 in the shower room at the toilet
- 7W washroom #1 toilet stall #1
- Resident room C716 at bed A

(101)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 25, 2013

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must ensure that furnishings, floors and walls are maintained in a good state of repair.

Grounds / Motifs :

1. The licensee failed to ensure that the home, its furnishings and equipment are maintained in a safe condition and in a good state of repair.

The servery doors of the 6th floor dining room were noted to be worn and scraped. Additionally, the legs of 41 dining room chairs were observed to be scuffed and worn with no finish left on them.

(128)

2. Painted door frames in communal washrooms and shower rooms were noted to be chipped throughout the home. (101)

3. Missing caulking at the base of resident toilets was noted in rooms 2C shower room #1 and shared identified resident toilet. (101)

4. Ceiling surfaces were noted to be water damaged with pieces of drywall hanging down and/or bubbled in the following areas of the home:
- Unit 6W washroom #4 in the shower room over the shower stall

- Unit 7W washroom #4
- Unit 7C washroom #1 in toilet stall #1 directly over the toilet. (101)

5. Washroom vanity counters were noted to be damaged/ cracked and/or chipped with some areas noted to have sharp edges exposed in the following washrooms in the home:
- Unit 2C shower room #1, shower room #2, washroom #2, washroom #3 and washroom #6
- Unit 4C washroom #4 in the shower room (101)

6. Damaged flooring with cracks, gouges, stained and/or worn surfaces were noted in the following areas of the home:
- Unit 2W Chapel, lounge, in front of the "Sound Garden" room, within shared identified resident toilet and another resident's toilet
- Unit 2C shower room #1 and shower room # 2
- Unit 4W washroom #4
- Unit 4C washroom #1
- Unit 5C washroom #3 in the shower room. (101)

7. Damaged wall surfaces were noted in the following areas of the home:
- Outside room C315 underneath the wall mounted hand sanitizer and where the handrail was raised leaving holes in the wall below.
- Chipped wall tiles in 5C washroom #3 shower room
- Unit 2C in the dining room on the east wall, an identified room, washroom #2, shower room #2
- Unit 2W in an identified shared resident toilet and another identified resident room. (101)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 27, 2013

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all elevators in the home that lead to the basement are equipped with a device to restrict resident access to this area that is not to be accessed by residents.
The plan shall outline the home's immediate, short-term and long-term strategies to ensure resident access to the basement is restricted.
The plan must be submitted by July 19, 2013.

Grounds / Motifs :

1. The licensee failed to ensure that the elevators in the home (1, 2, 3 and 4) are equipped with a device to restrict residents access to areas that are not to be accessed by residents. (101)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2014

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents.
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9. (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure all doors in the home leading to stairways and the outside of the home are:
- kept closed and locked and
- are equipped with a door access control system that is on at all times.

The plan shall outline the home's immediate, short-term and long-term strategies to ensure residents safety is maintained until compliance is reached by the below stated compliance date.
The plan must be submitted by July 19, 2013.

Grounds / Motifs :

1. The licensee failed to ensure that all the doors leading to stairways and the outside of the home
are kept closed and locked.

On June 5, 2013 at 12:28 the loading dock exterior doors were observed unlocked and unattended.
A Nutrition Manager acknowledged that the door was open and unattended and closed the door. (128)

2. On May 31, 2013, the following observations were made:
- At 12:15 the doors to the main floor stairways #2, #3 and #4 were not locked; all stairways were noted to lead to the basement, a non resident area.
- At 12:25 and 12:30, the double doors to the exterior loading dock area were observed open and unattended and did not preclude exit by a resident.
The Administrator was notified of this safety risk and while on tour with her, on the same day, the door to the exterior was found open and unattended again, at 13:12. The Administrator acknowledged that the expectation is that doors to the exterior are kept locked at all times.
(128)

3. The licensee failed to ensure that all doors leading to stairways and the outside of the home are equipped with a door access control system that is kept on at all times.

Doors #2, #3 and #4 leading to stairways and subsequently to the outside of the home are not equipped with a door access control system that is on at all times on the main level of the home. (101)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2014

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii. equipped with a door access control system that is kept on at all times, and
   iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

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

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents.

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

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

Order / Ordre :

The licensee shall ensure that all doors leading to stairways and the outside of the home are equipped with an audible door alarm that allows calls to be canceled only at the point of activation and is connected to:
(A) the resident–staff communication and response system, or
(B) an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

Grounds / Motifs :

1. All doors in the home leading to stairways and the outside of the home are not equipped with an audible alarm nor are they connected to the resident-staff communication and response system or an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. (101)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2014

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 006 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that lighting levels throughout the home meet the minimum illumination levels as outlined in the above requirement. (Table 18).

Grounds / Motifs :

1. Lighting levels were noted to be well below the minimum illumination levels in the following areas of the home:

-Unit 2C:
washroom #1- 102 lux
shower room #1- 79 lux
washroom #2- 108 lux
washroom #3- 96 lux
shower room #2 in shower stall- 62 lux
N hallway outside an identified resident room- 80 lux
W hallway outside washroom #4- 54 lux
washroom #4- 54 lux
washroom #6- 96 lux
landing area in front of the stairway #3- 57 lux
- Unit 2W
landing area in front of 'Resident Kitchen' on the E side of the dining room- 32 lux
centre of an identified resident room- 38 lux
shared resident toilet for two identified rooms- 202 lux
the hallway outside two identified resident rooms- 38 lux
- Unit 3C
landing area outside stairs- 38 lux
S lounge- 0 lux (light fixtures were not operational at the time of inspection)
hallway between two identified resident rooms- 100 lux
hallway between two identified resident rooms- 19 lux
hallway outside an identified resident room- 54 lux
hallway between two identified resident rooms- 53 lux
hallway outside an identified resident room- 15 lux
hallway between two identified resident rooms- 14 lux
hallway outside washroom #4- 59 lux
landing area in front of 'Tea Room' - 81 lux
landing area in front of 'Balcony' room- 100 lux
- Unit 3W
N-W lounge- 86 lux
hallway between stairway #2 and an identified resident room- 26 lux
hallway outside an identified resident room- 39 lux
hallway outside an identified resident room- 9 lux
hallway between two identified resident rooms- 57 lux
hallway between two identified resident rooms- 37 lux
hallway between two identified resident rooms- 59 lux
hallway outside 'Housekeeping' room- 14 lux

hallway between two identified resident rooms- 85 lux
- Unit 5W
landing area outside stairway #2- 15 lux
hallway outside an identified resident room- 13 lux
hallway outside an identified resident room- 18 lux
hallway between two identified resident rooms- 28 lux
hallway in front of nursing station- 37 lux
- Unit 5C
hallway between stairway #3 and an identified resident room- 90 lux
hallway outside an identified resident room- 11lux
hallway between resident rooms C507-508- 68 lux
hallway between two identified resident rooms- 32 lux
hallway outside 'Housekeeping' room- 19 lux
- Unit 7C
landing area outside stairway #3- 72 lux
hallway between resident rooms C702-703- 44 lux
S lounge- 41 lux
hallway between two identified resident rooms- 34 lux
hallway outside 'Housekeeping' room- 12 lux
N lounge- 184 lux
hallway outside an identified resident room- 22 lux
landing area in front of elevator #3- 29 lux
- Unit 7W
landing area outside stairway #2- 10 lux. (101)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2014

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Order # / Ordre no : 007 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The license shall prepare, submit and implement a plan to ensure that water temperatures are maintained below 49 degrees Celsius at all times in the home. The plan shall outline the home's immediate, short-term and long-term strategies to ensure water temperatures do not exceed 49 degrees Celsius in resident accessible areas.
The plan must be submitted by August 1, 2013.

Grounds / Motifs :

1. The licensee failed to ensure that procedures are implemented to ensure that the temperature of the water serving all bath tubs, showers and hand basins used by residents does not exceed 49 degrees Celsius.

Water temperatures were noted to exceed 49 degrees Celsius during noted periods of time on June 4 and June 6, 2013 at 11:00, 15:00 and 17:00 on Unit 3W, 3C, 4C, 4W and 6C.
A review of the home's manual water temperatures checks for the past 4 months revealed water temperatures to be recorded at 49 degrees Celsius consistently despite the fact that at the time of the inspection water temperatures were noted to fluctuate throughout the days and were noted to exceed 49 degrees C at different periods of the day including the same times in which the home records temperatures. (101)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 25, 2013

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 : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg 79/10, s. 73. (1) to ensure that that the home has a dining and snack service that includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
The plan must include who will be responsible for ongoing monitoring to ensure that a sustainable system is put in place to monitor meal and snack service to safeguard that residents are assisted/fed safely at all times, including safe positioning.
The plan must also identify how and when education will be provided to all staff, including registered staff, as well as who will be responsible for providing the education.
The plan must be submitted by July 19, 2013.

Grounds / Motifs :

1. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who require assistance.

On June 3, 2013, at the lunch meal, resident #42 was observed coughing. The resident was observed to be at an unsafe feeding height while being assisted with eating by a PCA.
During a staff interview, the PCA acknowledged that the resident was not being assisted at the proper feeding height and indicated awareness of the proper height when assisting residents. A few minutes later another PCA sat down on the stool to assist the resident. The PCA also acknowledged that the stool was at an inappropriate height but did not change the height of the chair. The resident did not consume any more of the meal.
On June 5, 2013, at 9:08, resident #28, was observed being fed breakfast in bed. The resident was not at a safe feeding height and was heard gurgling.
An interview with the Registered staff who was feeding the resident revealed that the resident should be fed in an upright position and at eye level. The Registered staff acknowledged that the resident was not at eye level while being assisted with breakfast and that the resident is at high risk of choking and is quite congested.
Inspector #128 inquired if the bed position could be altered and the Registered staff confirmed that it did and raised the bed to a height where the resident was at eye level.
A staff interview with a Nutrition Manager and a RD revealed that staff are

expected to be seated as close to a 90 degree angle, as possible. They stated "there are set expectations when assisting a resident and staff are expected to be seated in the feeding chairs which would put them at eye level", noting that the chairs are adjustable.
On June 7, 2013, at 09:05 a PCA was observed assisting resident #41 to eat breakfast in the 3rd floor dining room. The PCA was seated approximately 18 inches above the resident's eye level. MOHLTC intervention was provided related to the resident being at potential choking risk.
The PCA stated "I have no idea" what an appropriate safe position would be for residents who require assistance with eating. " I guess that I should be lower than his chair but I don't know. This chair won't go any lower. Half the chairs we have up here are broken".
On June 7, 2013 at 12:28, two residents were observed being assisted with eating in an unsafe position, in the 3rd floor dining room:
Resident #43 was being assisted by a Registered staff member.
During a staff interview the Registered staff indicated that the resident was not in a safe feeding position, and the staff should be at the eye level. After acknowledging that the height was not at eye level, the staff lowered the chair to be at eye level.
Resident #44 was also being assisted at the same table by a PCA.
During a staff interview, it was indicated that the staff should be at eye level. Despite acknowledging that she was not at eye level, she stated that the height of the chair could not be altered. (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 19, 2013

Order # / Ordre no : 009 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(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).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance to ensure that drugs are stored in an area or a medication cart that is secure and locked. The plan must be submitted by July 19, 2013.

Grounds / Motifs :

1. The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On May 29, 2013, at 16:50, on 3W unit, the inspector observed an unattended medication cart in the hallway outside the dining room. There were 2 packages of crushed medication on the top of the cart. Staff interview revealed that the expectation is that medications are not to be left unattended.
(128)

2. On May 29, 2013, at 16:00, inspector #124 observed on unit 3 that the medication room was unlocked, the medication room door was open and the medication cart for the W side was also unlocked. At this time, the medication

room was unsupervised. This was acknowledged by an identified Registered staff.
On June 4, 2013 at 10:51, inspector #124 observed on the unit 3 that the medication room door was open, both medication carts were unlocked and the medication room was unsupervised. (124)

3. On June 6, 2013 at 11:45 the medication cart on 7W was observed unlocked in the lounge area while the Registered staff was administering medication in the dinning room and was not able to observe the medication cart.
Residents and visitors were passing by at that time. (193)

4. On June 3, 2013 at 07:50, the door to the treatment room on 6W was unlocked. Inside of the room was an unlocked treatment cart with topical prescription medications. There was no Registered staff in the area.
On June 9, 2013 at 09:15, 2 treatment carts on 7W which contained topical prescription medications were noted to be unlocked in the treatment room. Upon further inspection it was determined that 1 of the treatments carts did not lock. This was reported to the Nurse Manager.
On June 10, 2013 at 7:55, the door to the treatment room on 7W was unlocked. The room contained 2 unlocked treatment carts with topical prescription medications. This was reported to the Nurse Manager.
On June 11, 2013 at 9:05, the door to the treatment room on 6W was unlocked. The room contained 2 unlocked treatment carts with topical prescription medications. It was reported to the Registered staff who locked the door. (153)

5. On June 6, 2013 at 8:45 on 3rd floor, the treatment room door was open and 2 unlocked treatment carts containing topical prescription medications were observed inside of the room .

(142)

6. On June 4, 2013 at 08:56 on 4th floor, the treatment cart was observed locked in the hallway between rooms C405 and C404. However, the cart has a push/turn lock which does not require a key to unlock it and does not restrict access to the topical prescription medications available in the cart.
(142)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 02, 2013

Order # / Ordre no : 010

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

Pursuant to / Aux termes de :

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

Order / Ordre :

To prepare, submit and implement a plan for achieving compliance to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home and the Administrator. The plan must be submitted by July 19, 2013.

Grounds / Motifs :

1. On June 5, 2013 it was observed and confirmed by the Registered staff on 5th and 7th floor that the key for the treatment room is the same key used for the linen chute. The key is kept in the nursing station on the wall and PCAs are using it to get access to the linen chute and to continence care products. The treatment carts contain prescribed topical medications and are kept unlocked in the treatment room when not in use.
(193)

2. The licensee failed to ensure all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On June 3, 2013 at 09:00, inspector #153 requested access to the 6W medication room and the door was opened by the nursing clerk who had the keys to the medication room on a lanyard around her neck. In the medication room are stored regular and controlled substances. The nursing clerk does not dispense, prescribe or administer medications in the home.
On June 4, 2013 at 10:50 the nursing clerk from the main floor was observed to transport the discontinued drugs to the Central Supply Room in the basement and unlock with a key to the medication room where the stock medications are stored along with the surplus drugs waiting for destruction. The nursing clerk does not dispense, prescribe or administer medications in the home.
(153)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 02, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 5th day of July, 2013

Signature of Inspector / Signature de l'inspecteur :

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

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