Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 8, 2014	2014_265526_0016	H-000953-14	Resident Quality Inspection

Licensee/Titulaire de permis

DEVONSHIRE ERIN MILLS INC.
195 DUFFERIN AVENUE, SUITE 800, LONDON, ON, N6A-1K7

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

ERIN MILLS LODGE NURSING HOME
2132 DUNDAS STREET WEST, MISSISSAUGA, ON, L5K-2K7

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

THERESA MCMILLAN (526), ASHA SEHGAL (159), DIANNE BARSEVICH (581), JENNIFER ROBERTS (582), KELLY HAYES (583), YVONNE WALTON (169)

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): July 23, 24, 25, 28, 29, 30, and 31, 2014.

The following inspections were conducted simultaneously to this RQI inspection: H-000466-14, H-000408-14, H-000651-13, and follow up inspection H-000427-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Manager/ADOC, Food Services Supervisor or their delegate, Registered Dietitian (RD), Programs Manager, Staffing Coordinator, registered staff, personal support workers (PSWs), maintenance staff, housekeeping staff, recreation staff, dietary aides (DAs), residents and family members.

During the course of the inspection, the inspector(s) toured the home; reviewed policies and procedures, meeting minutes, resident health records, dietary menus and staff files; and observed residents in their living and dining areas

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure resident #102 was protected from abuse and neglect by staff.

The incident that occurred involved a PSW verbally telling the resident to not ring the call bell for assistance. The resident had limited mobility, was in pain and needed assistance from staff for care. The PSW told the resident not to ring the call bell on the night shift. This form of verbal communication toward the resident diminished the resident's sense of well-being, dignity and self-worth. The resident identified they felt sad and not worthy, therefore stopped ringing the call bell for assistance and remained in the same position in bed. The resident was also denied care and assistance required for health, safety and well-being that jeopardized their health, safety and well-being. This was confirmed by the Director of Care and the resident. The documentation, critical incident submitted to the Ministry of Health also confirmed this occurred. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with 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 did not ensure that the planned menu items were offered and available at each meal and snack.

A) Breakfast service was observed in a dining room on a day in July, 2014. The posted menu indicated that cinnamon raisin scones would be available. It was observed that the residents were not offered the cinnamon raisin scones and the dietary aide explained they were not sent up with the breakfast food items. An interview with the acting Food Service Supervisor, confirmed that the planned scones were not available and muffins were sent as a substitution.

B) Breakfast service was observed in a dining room on a day in July, 2014. A review of the diet list used by the dietary aides and personal service workers (PSWs) indicated resident #301 and #302 were to receive a supplement with meals. A review of plans of care showed resident #301 and resident #302 were ordered supplements with meals. Towards the end of a meal service it was observed that these residents were not offered the supplements. In an interview with the registered staff it was confirmed that resident #301 and #302 did not receive their supplement as per their planned menu. [s. 71. (4)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and O. Reg. 79/10, s. 90 (1).
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(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; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee did not ensure that (a) resident rooms and washrooms were maintained in good repair; and (b) there were schedules and procedures in place for routine, preventive and remedial maintenance of resident rooms and washrooms.

The home's maintenance policy for "Interior - General Maintenance Furnishings, Walls, Flooring, Safety Devices" number ESM04-01-19 last reviewed February 2013 indicated that the home was "responsible for setting out specific procedures and pre-scheduled routines for monitoring and repairing flooring, carpets, walls, ceilings, doors, furnishings, toilet, sinks, bathing fixtures, grab bars, faucets for resident use and protective guards".

A) On July 24, 2014 the bath tub on Hazel Lane (HL) was observed to have no shower head attached to the hose that would normally be used to bathe residents while using the bath tub. Staff and the Director of Care (DOC) confirmed that the bath tub fixture was broken and non functional in the event that a resident wished to be bathed there. The tub room was noted to have soiled, broken boards formed into the shape of a box and placed beneath the sink. The wall and tile approximately 20 centimetres (cm) by 10 cm was missing beside the toilet.

B) On July 28, 2014 between 1230 and 1330 hours observations were made in the following rooms: HL315, baseboards were in disrepair and ripped away from the walls;

HL309, baseboards/walls scraped and damaged; HL314, wall cut away and not repaired behind toilet; HL311, corner of wall at entry to the room and baseboard removed/damaged with plaster falling away at the walls edge; HL319, corner baseboard coming away from the wall about 10 cm by 15 cm.

C) On July 31, 2014, maintenance of plumbing fixtures, sinks, and washroom fixtures and accessories in 12 resident rooms on Erindale Place (EP) and eight rooms on Sheridan Way (SW) were randomly inspected. The following rooms were found to have faucets that were leaking and corroded with stains: EP 303, 305, 306, 307, 308, 309, 311, 312, and 313; on SW 316, 317, 319, 321, 322, 323, and 324. Sinks that were cracked, corroded with rust stains included EP 305, 308, 309, 310, 311, 312, and 313; on SW 316, 319, 321, 322, and 324.

D) On July 31, 2014 tiles and floors were noted to be in disrepair in resident rooms and/or bathrooms EP 305, 306, 308, 309, 310, 311, 312, and SW317, 319, 320, 321, 322, 323, and 324.

E) On July 31, 2014, walls were noted to be in disrepair with cut outs and chunks taken out of dry wall in rooms EP 308, 309, and SW 316, 317, 321, and 322.

The Administrator confirmed that the home did not have a schedule for routine maintenance for resident rooms and washrooms, and could not confirm that regular maintenance in resident rooms and washrooms had been completed. [s. 90. (1)]

2. The licensee did not ensure that procedures were implemented to ensure that the hot water temperature serving all bath tubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius. On July 27, 2014 at 1300 hours, non registered staff verified the location of the shower residents used on bath day on Hazel Lane resident care area. Non registered staff verified that the water temperature in this shower ranged from 36.8 to 38 degrees Celsius according to the thermometer measurement. On July 29, 2014 at 0915 hours, the water temperature ranged between 36.8 and 38 degrees Celsius. The Administrator stated that staff taking water temperatures should have notified maintenance if the water temperature fell outside of the range of 40 to 49 degrees. The Administrator confirmed that staff were testing the water at the sink in the tub room rather than the shower most used by residents. The Administrator confirmed that the water temperature in the shower used by residents was below the required 40 degrees celsius. [s. 90. (2) (i)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not fully respect and promote the residents' right to live in a safe and clean environment.

On July 28 and 29, 2014 the bathrooms in resident rooms 309 and 315 on Hazel Lane resident care area were found to be unclean. The raised toilet seat of room 309 had urine, stool and blood debris on the raised toilet seat for two days. A resident who lived in this room stated that they relied on staff to keep it clean. The resident stated that, in the past, this resident's family had reported to the resident that the toilet seat was soiled. The resident stated that using a soiled toilet seat did not respect their right to live in a clean environment. The raised toilet seat in room 315 was noted to be soiled with stool and urine. A resident living in this room stated that the toilet seat was soiled and should be cleaned. Registered and non registered staff confirmed that these washroom facilities were soiled and should be cleaned. [s. 3. (1) 5.]

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 rights of residents to live in a safe and clean environment is respected,, to be implemented voluntarily.

WN #5: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure the plan of care set out clear directions to staff and others who provided care to the residents.

A) A review of the plan of care showed that resident #003 required a supplement three times per day with meals. A review of the home area's Dining Room guideline and "Nutrition Information Of All Clients-Diet/Snack" located in the dining room did not identify that resident #003 required a supplement. During interview, the dietary aides (DA), personal support workers (PSW) and registered nursing staff stated explained that DA's and PSW's refer to these documents to identify residents' nutrition requirements and that PSW's were responsible for providing the supplements to residents at mealtimes. During an interview with (PSW)'s it was identified they did not know when or how much suplement to provide resident #003. A review of the "Dietary Report" showed that resident #003 was documented as being offered the supplement five times out of a possible 90 times during a month in 2014. It was verified with the PSW's that clear direction was not provided in relation to supplements required for resident #003.

B) A review of the plan of care showed that resident #006 required a supplement three times per day with meals. A review of the home area's Dining Room guideline and

"Nutrition Information Of All Clients -Diet/Snack" located in the dining room identified that resident #006 required a supplement, but did not specify when or how often. In an interview with the dietary aides (DAs), personal support workers (PSWs) and registered nursing staff if it was explained that DA's and PSWs refer to these documents to identify residents nutrition requirements and that PSWs were responsible for providing the supplements to residents. During interview, PSWs identified how much supplement they thought the resident should receive. A review of the "Dietary Report" showed that resident #006 did not have documentation that the supplement was provided. It was verified with the PSWs that clear direction was not provided in relation to supplements required for resident #006. [s. 6. (1) (c)]

2. The licensee did not ensure that residents were reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A) A review of the plan of care showed that resident #006 had bed rails that were initially assessed as a restraint. It was identified that the bed rails were assessed during a month in 2014 using the "Safety Risk Assessment (Revised)" tool. A review of the Resident Care Manual Restraint Policy RCM09-01-01, last revised August 2011 indicated restraints were to be reassessed every 3 months per the quarterly Resident Assessment Inventory Minimal Data Set (RAI MDS) assessment. An interview with the ADOC confirmed that the bed rails were not assessed during the next RAI MDS assessment. The ADOC also confirmed by that the expectation was that all restraints were reassessed quarterly.

B) The plan of care for resident #006 described the resident's continence patterns. Personal support worker (PSW) and registered staff described the resident's continence patterns and care. The plan of care and kardex were not consistent with the care as described. The RAI Manager and the registered staff verified the plan was not revised and updated when the residents continence care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds were assessed by a registered dietitian who was a member of the staff of the home.

A review of the plan of care for resident #006 showed they developed altered skin integrity during a month in 2014. In an interview with the registered nursing staff it was shared that the a referral was made to the Registered Dietitian (RD) at that time and that, at the time of the inspection, the altered skin integrity had become worse. A review of the plan of care showed that the RD completed the assessment and the nutrition interventions were implemented almost two months after the wound was first identified. The RD confirmed that the assessment and nutrition interventions occurred as indicated in the resident's plan of care. [s. 50. (2) (b) (iii)]

2. The licensee did not ensure that a resident exhibiting altered skin integrity, including skin breakdown had been reassessed at least weekly by a member of the registered nursing staff as clinically indicated.

Progress notes indicated that registered staff had identified an alteration in skin integrity during month in 2014. Over a period of two and one half months, the resident's altered skin integrity had not been assessed weekly on three separate occasions. Progress notes confirm that during this time period the altered skin integrity deteriorated. The ADOC confirmed that weekly skin assessments had not been completed for resident #006's altered skin integrity and that there was a deterioration in the resident's status during that time. [s. 50. (2) (b) (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 residents exhibiting altered skin integrity are iii) assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented; and iv) reassessed at least weekly by a member of the registered nursing staff, if clinically indicated,, to be implemented voluntarily.

WN #7: 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).

Findings/Faits saillants :

1. The licensee did not ensure that the food production system provided for standardized recipes for all menus.

A) Not all the recipes were consistent with the quantities of the menu items specified on the production sheet report. The recipes available for staff were not scaled and adjusted for the number of servings required for the planned menu. On July 21, 2014 recipe used for fried rice was for 54 servings, however, the production report had identified 44 regular servings, 10 servings pureed and 12 servings of fried rice for minced diet. The Food Service Supervisor confirmed the recipes were not adjusted for the number of servings required.

B) On July 21, 2014 a review of recipes and the food production observations confirmed that the protein content of entrée (Fried Rice) did not meet the nutritional adequacy of the planned menu. The Food Service Supervisor (FSS) reported the fried rice recipe available was for 54 servings, the ingredients listed in the recipe did not supply enough protein to constitute 2 servings of 50 gram protein. The recipe called for 500 ml liquid eggs, which supplied less than .30 gram of protein per serving. The FSS confirmed the recipe was computerized, however, some ingredients listed in the recipe were substituted (shrimps were substituted with eggs) but the protein content was not adjusted for the substitution made. The fried rice entree served for lunch tasted was found very dry and lacked flavour. The FSS interviewed confirmed the entrée was not well received by majority of residents and there was a high plate waste. The nutritional adequacy of the menu item was compromised and did not meet the required protein servings of the planned menu.

C) The dietary staff preparing the lunch meal on July 21, 2014 did not follow recipes consistently. Minced submarine sandwich filling was prepared without weighing/ measuring of ingredients. This would affected the nutritive value of the menu item served as the quantities of ingredients such as meat used was less than required. The recipe available did not provide clear directions for staff. The dietary staff interviewed was unable to identify the measurements and the quantities of the ingredients listed in the recipe and confirmed the recipe was not followed.

D) The staff did not follow pureed fried rice recipe. The recipe available had called for the use of prepared product. The Food Service Manager interviewed reported the pureed fried rice was prepared earlier and the cook did not use the prepared regular product as specified in the recipe. [s. 72. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the food production system, at a minimum, provides for c) standardized recipes and production sheets for all menus,, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that a documented record was kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant?

During 2014, the family of resident #102 brought three separate allegations of abuse to the management team. There was no documented record of the complaint including the nature, date, type of action taken, final resolution, date of any response provided or received. This was confirmed by a review of the complaint log and interview with the Director of Care. [s. 101. (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 a documented record is kept in the home that includes (a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant,, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 227. Regulated documents

Specifically failed to comply with the following:

s. 227. (1) For the purposes of section 80 of the Act, the following are regulated documents:
1. Any agreement between the licensee and a resident or a person authorized to enter into such an agreement on the resident's behalf for any of the charges referred to in subsection 91 (1) of the Act. O. Reg. 79/10, s. 227 (1).

Findings/Faits saillants :

1. The licensee did not ensure that any agreement between the licensee and a resident or a person authorized to enter in to such an agreement on the resident's behalf was in accordance with any of the charges referred to in subsection 91(1). The admission contracts were reviewed for six residents. The admission contract for resident #414 indicated that the resident's accommodation was different from what was observed during this inspection. The regulated contract did not identify the current monthly accomodation charge for resident #414. This was confirmed by documentation of the admission agreement and interview with the Administrator. [s. 227. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any agreement between the licensee and the resident or a person authorized to enter in to such an agreement on the resident's behalf is in accordance with any of the charges referred to in subsection 91(1),, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee did not ensure that staff participated in the implementation of the home's infection prevention and control program. The home's infection control manual for Disinfecting Personal Equipment IC02-01-13 last reviewed on October 2011 indicated that "nail clippers will be cleaned and disinfected...after each use, weekly and when needed". As instructed, staff were to label and store nail clippers individually.

On July 28 and 29, 2014, inspector observed the storage area for residents' nail clippers on the home's three resident care areas. In each case, nail clippers were stored in containers with compartments labeled with resident room numbers. Multiple nail clippers were found in compartments for rooms with more than one resident and nail clippers were not consistently labeled with residents' names and/or room numbers. Skin and nail debris were noted on clippers and within each container with multiple nail clippers. Registered staff and the ADOC confirmed that the practice of storing resident's nail clippers was unsanitary; they should be cleaned after each use and should be stored in individual compartments for each resident. [s. 229. (4)]

2. The licensee did not ensure that a resident admitted to the home was screened for tuberculosis (TB) within 14 days of admission, unless the resident had already been screened at some point in time in the 90 days prior to admission. Two of three residents' health records inspected for TB screening revealed inadequate screening. Not only were these two residents screened greater than 14 days following admission but the screening was not complete as Step 2 had not been completed. The Infection Control Person confirmed that the residents had not been adequately screened for TB. [s. 229. (10) 1.]

3. The licensee did not ensure that staff were screened for tuberculosis (TB) in accordance with evidence based practices or prevailing practices. Staff files were reviewed on July 30, 2014. The Staffing Coordinator could not confirm that one staff member had been screened for TB prior to their start date and confirmed that a second staff person was not screened for TB prior to their start date. [s. 229. (10) 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 staff participate in the implementation of the home's infection prevention and control program,, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure the plan of care was based on an interdisciplinary assessment of a resident's nutritional status including risks related to nutrition care.

The plan of care was reviewed for resident #006 over a four month time period in 2014. As per the resident's plan of care, resident #006 was to receive a nutritional treatment three times per day for an alteration in skin integrity. A review of the "Physician's Order Form" showed the physician had discontinued this treatment. Two months later, an interview with the Registered Dietitian (RD) indicated that they were unaware the nutrition intervention had been discontinued and a reassessment had not been completed. The RD last assessed resident just prior to the treatment being discontinued. In an interview with the registered nursing staff it was confirmed that the nutrition intervention was no longer being provided, and that resident #006's alteration in skin integrity had worsened over the four month period. [s. 26. (3) 13.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee did not ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. Inconsistencies in the assessment of continence was noted over three separate quarterly Resident Assessment Instrument Minimum Data Set (RAI MDS) assessments for resident #006.

The registered staff and the Resident Assessment Instrument (RAI) Coordinator confirmed that resident #006 was not assessed using a clinically appropriate assessment instrument that was specifically designed for continence, when the resident's continence status had changed. [s. 51. (2) (a)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 63. If invited by the Residents' Council or the Family Council, the licensee shall meet with that Council or, if the licensee is a corporation, ensure that representatives of the licensee meet with that Council. 2007, c. 8, s. 63.

Findings/Faits saillants :

1. The licensee did not meet with Family Council when invited. A record review indicated that Family Council had invited the manager of housekeeping on May 23, 2014 to attend Family Council. Emails provided by a family council member indicated that Family Council asked if the manager of housekeeping could attend the next meeting dated June 17, 2014 at 0600 and included the Administrator on the request. A representative did not attend the June 17 or July 29, 2014 Family Council Meeting to address council's housekeeping concerns. The council had not received any follow up related to when a representative was able to attend. [s. 63.]

WN #14: 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:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the dining and snack service included a review of the meal and snack times by the residents. On July 23, 2014 the second seating lunch service in the Erindale dining room was observed to start at 1320 hours. The Residents' Council meeting minutes were reviewed from July 2013 to July 2014 and did not identify that the residents had approved the meal and snack service times. In an interview with the Director of Care it was explained that meal service for the second seating was scheduled for 0900, 1300 and 1800 hours and that the meal and snack times had not been reviewed with the Residents' Council. [s. 73. (1) 2.]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

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 did not seek the advice of the Residents' Council in the development and carrying out of the satisfaction survey, or include them in acting on the results.

A review of the Residents' Council meeting minutes from July, 2013 to July, 2014 indicated that there had not been any discussion at council regarding the satisfaction survey. In an interview with the Programs Manager and the Administrator it was confirmed that the home did not seek Residents' Council input in the development and carrying out of the satisfaction survey, or include them in acting on the results. [s. 85. (3)]

2. The licensee did not ensure the satisfaction survey results were made available to the Residents' Council as required in order to seek the advice of the council about the survey.

A review of the Residents Council meeting minutes from July, 2013 to July, 2014 indicated that there had not been any discussion at council regarding the satisfaction survey. In an interview with the Programs Manager and the Administrator it was confirmed that the home did not ensure the satisfaction survey results were made available to the Residents' Council as required in order to seek the advice of the council about the survey. [s. 85. (4) (a)]

WN #16: 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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were implemented for cleaning the home including resident bedrooms. On July 24, 28, and 29, 2014, resident rooms and

washrooms in resident care areas on Hazel Lane (HL) and Erindale Place (EP) were randomly inspected for housekeeping.

A) Floor Cleaning: The home's Housekeeping policy for Floor Cleaning ESM02-01-11 last reviewed in February 2013 directed staff ensure that various floor types were routinely cleaned; to establish procedures for the methods used to clean each floor type; and to audit floor cleaning procedures and results. Floors in resident rooms HL 303, 315 and 309 were soiled with black debris and were sticky to walk on. Staff confirmed that floors in resident care areas were soiled and sticky. On July 29, 2014, the Administrator confirmed that the housekeeper had been using the wrong cleaning solution that was not designed for cleaning floors.

B) Privacy Curtains: The home's Housekeeping policy for Cleaning Procedures ESM02-01-09 last reviewed on February 2013 directed staff to inspect curtains daily for stains, missing hooks or repairs and to replace missing hooks or remove for washing/repair if required. Privacy curtains in rooms HL 303, 315 and EP 303 and 307 were soiled and frayed and had hooks missing. Staff confirmed that the privacy curtains were soiled and damaged and should have been replaced.

C) Cleaning of Washrooms: The home's Housekeeping policy for Cleaning Procedures ESM02-01-09 last reviewed on February 2013 regarding general cleaning of washrooms were designed to maintain cleanliness, control bacteria and odour, and maintain acceptable aesthetic conditions. The policy directed staff to completely spray the inside and outside of the toilet with germicidal cleaner, allow moisture to stand. Then housekeeping staff were to wipe the exterior of the toilet and use a toilet bowl mop inside the toilet bowl. The raised toilet seats in three of six resident washrooms (HL 303, 315 and 309) were found to be soiled with urine and feces and were not cleaned between July 28 and 29, 2014. Registered and non registered staff confirmed that the toilet seats were unclean and did not maintain acceptable aesthetic conditions.

Family Council notes dated May 20, 2014 indicated that the Family Council complained to the home that the home was unclean. At that time the home indicated that a deep cleaner had been hired to start on July 28, 2014. Registered and non registered staff and the Administrator confirmed that the housekeeping programme in the home was not effective in maintaining the home in a state of cleanliness. [s. 87. (2) (a)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee did not ensure that linens and bath towels were maintained in a good state of repair. The home's Laundry policy regarding "Inspection of Linens" ESM03-01092 last reviewed on February 2013 directed staff to inspect all linen daily; to remove all damaged or worn linen from circulation and place in designated areas; to count and record the discarded linen using the "Linen Discard Form" which would be forwarded to the Environmental Services Manager (ESM); the ESM would follow the home's process to repair or replace damaged or worn linens.

On July 28 and 29, 2014, carts on resident care areas being used to distribute linens contained bath towels and hand towels that were in a state of disrepair including being ripped, shredded and frayed at the edges. Non registered staff on Sheridan Way (SW) described how fresh linens were distributed to carts for staff to distribute to residents. Two of eight towels on the cart were found to be frayed and ripped on SW resident care area. Two of five towels were found to be frayed on Erindale Place (EP) resident care area. Two of five towels were found to be frayed and ripped on Hazel Lane (HL) resident care area. Staff interviewed stated "we are forced to use these because towels are always in short supply". Staff also indicated that they used the newer towels first and then the ripped ones toward the end of providing care.

Upon inspection of the laundry, frayed and ripped towels were found on the linen carts being prepared to be sent to the resident care areas for use. Staff in the laundry confirmed that the towels were on the cart and ready to be sent to the floor. They confirmed that they should not have been placed on the carts for used by staff with residents and that they should have been discarded; they then discarded the ripped towels in a bin beneath a folding table. Staff confirmed that they were not aware of the home's policy for inspection of linens. Inspector noted that the "Linen Discard Form" was not posted; the laundry staff and Administrator confirmed this.

The Administrator confirmed that some towels that were in resident care areas and on linen carts for distribution and use in resident care areas were not maintained in a state of repair. [s. 89. (1) (c)]

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:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 72. (3)	CO #001	2014_190159_0010	159

Issued on this 19th day of September, 2014

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	THERESA MCMILLAN (526), ASHA SEHGAL (159), DIANNE BARSEVICH (581), JENNIFER ROBERTS (582), KELLY HAYES (583), YVONNE WALTON (169)
Inspection No. / No de l'inspection :	2014_265526_0016
Log No. / Registre no:	H-000953-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 8, 2014
Licensee / Titulaire de permis :	DEVONSHIRE ERIN MILLS INC. 195 DUFFERIN AVENUE, SUITE 800, LONDON, ON, N6A-1K7
LTC Home / Foyer de SLD :	ERIN MILLS LODGE NURSING HOME 2132 DUNDAS STREET WEST, MISSISSAUGA, ON, L5K-2K7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARY WHALEN

To DEVONSHIRE ERIN MILLS INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. The licensee did not ensure resident #102 was protected from abuse and neglect by staff.

The incident that occurred involved a PSW verbally telling the resident to not ring the call bell for assistance. The resident had limited mobility, was in pain and needed assistance from staff for care. The PSW told the resident not to ring the call bell on the night shift. This form of verbal communication toward the resident diminished the resident's sense of well-being, dignity and self-worth. The resident identified they felt sad and not worthy, therefore stopped ringing the call bell for assistance and remained in the same position in bed. The resident was also denied care and assistance required for health, safety and well-being that jeopardized their health, safety and well-being. This was confirmed by the Director of Care and the resident. The documentation, critical incident submitted to the Ministry of Health also confirmed this occurred. (169)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 22, 2014

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the planned menu items are offered and available at each meal and snack.

Grounds / Motifs :

1. Previous non compliance issued as a Compliance Order on November 7, 2013.

2. The licensee did not ensure that the planned menu items were offered and available at each meal and snack.

A) Breakfast service was observed in a dining room on a day in July, 2014. The posted menu indicated that cinnamon raisin scones would be available. It was observed that the residents were not offered the cinnamon raisin scones and the dietary aide explained they were not sent up with the breakfast food items. An interview with the acting Food Service Supervisor, confirmed that the planned scones were not available and muffins were sent as a substitution.

B) Breakfast service was observed in a dining room on a day in July, 2014. A review of the diet list used by the dietary aides and personal service workers (PSWs)indicated resident #301 and #302 were to receive a supplement with meals. A review of plans of care showed resident #301 and resident #302 were ordered supplements with meals. Towards the end of a meal service it was observed that these residents were not offered the supplements. In an interview with the registered staff it was confirmed that resident #301 and #302 did not receive their supplement as per their planned menu. (583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,

(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and

(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that (a) maintenance services in the home are available to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. The plan shall summarize the following:

1. Short-term actions:
a) that ensure that the home's preventive and remedial maintenance schedule includes flooring, walls, ceilings, doors, furnishings, toilets, sinks, bathing fixtures, grab bars, faucets and protective guards in resident bedrooms, washrooms and tub rooms as per the home's policy ESM04-01-09.

b) to maintain and repair areas of disrepair in resident rooms, washrooms, and tub rooms.

2. Long-term actions: to address how the preventive and remedial maintenance programme will be monitored to ensure that resident rooms, washrooms and tub rooms are maintained as per policy ESM04-01-09.

The plan shall be submitted by September 30, 2014 to Long Term Care Homes Inspector Theresa McMillan at Theresa.McMillan@Ontario.ca. The plan is to be implemented by 2014. If this date is not suitable, please contact the inspector for an extension as soon as possible.

Grounds / Motifs :

1. Previously issued non compliance as a Voluntary Plan of Correction, Inspection Number 2013_190159_0030.

2.The licensee did not ensure that (a) resident rooms and washrooms were maintained in good repair; and (b) there were schedules and procedures in place for routine, preventive and remedial maintenance of resident rooms and washrooms.

The home's maintenance policy for "Interior - General Maintenance Furnishings, Walls, Flooring, Safety Devices" number ESM04-01-19 last reviewed February 2013 indicated that the home was "responsible for setting out specific procedures and pre-scheduled routines for monitoring and repairing flooring, carpets, walls, ceilings, doors, furnishings, toilet, sinks, bathing fixtures, grab

bars, faucets for resident use and protective guards".

A) On July 24, 2014 the bath tub on Hazel Lane (HL) was observed to have no shower head attached to the hose that would normally be used to bathe residents while using the bath tub. Staff and the Director of Care (DOC) confirmed that the bath tub fixture was broken and non functional in the event that a resident wished to be bathed there. The tub room was noted to have soiled, broken boards formed into the shape of a box and placed beneath the sink. The wall and tile approximately 20 centimetres (cm) by 10 cm was missing beside the toilet.

B) On July 28, 2014 between 1230 and 1330 hours observations were made in the following rooms: HL315, baseboards were in disrepair and ripped away from the walls; HL309, baseboards/walls scraped and damaged; HL314, wall cut away and not repaired behind toilet; HL311, corner of wall at entry to the room and baseboard removed/damaged with plaster falling away at the walls edge; HL319, corner baseboard coming away from the wall about 10 cm by 15 cm.

C) On July 31, 2014, maintenance of plumbing fixtures, sinks, and washroom fixtures and accessories in 12 resident rooms on Erindale Place (EP) and eight rooms on Sheridan Way (SW) were randomly inspected. The following rooms were found to have faucets that were leaking and corroded with stains: EP 303, 305, 306, 307, 308, 309, 311, 312, and 313; on SW 316, 317, 319, 321, 322, 323, and 324. Sinks that were cracked, corroded with rust stains included EP 305, 308, 309, 310, 311, 312, and 313; on SW 316, 319, 321, 322, and 324.

D) On July 31, 2014 tiles and floors were noted to be in disrepair in resident rooms and/or bathrooms EP 305, 306, 308, 309, 310, 311, 312, and SW317, 319, 320, 321, 322, 323, and 324.

E) On July 31, 2014, walls were noted to be in disrepair with cut outs and chunks taken out of dry wall in rooms EP 308, 309, and SW 316, 317, 321, and 322.

The Administrator confirmed that the home did not have a schedule for routine maintenance for resident rooms and washrooms, and could not confirm that regular maintenance in resident rooms and washrooms had been completed. (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 09, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 8th day of September, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Theresa McMillan

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