Findings/Faits saillants :

1. [O.Reg. 79/10, s. 36]
The licensee did not ensure that staff used safe transferring and positioning devices or techniques when assisting residents. According to the home's policy "Mechanical Lifts" section M (1): prior to initiating a resident transfer or lift, all staff are responsible for ensuring they are aware of and follow the resident's assessed and posted method of lift and transfer (5) all lifts/transfers completed with a mechanical lift require the participation of a minimum of two staff members. On a specified day in 2012, one personal support worker transferred an identified resident using the sit to stand "sara" mechanical lift, despite the resident's plan of care which indicated the resident was unable to weight bear and required staff to use the "maxi" mechanical lift for all transfers. Staff reported the resident was improperly strapped into the lift during this transfer. The resident was lowered to the floor without injury.

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 with ensuring that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following subsections:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 35(2)]
The licensee failed to ensure that residents received fingernail care, include the cutting of fingernails.
a) An identified resident was observed on May 3, 2012 and May 28, 2012 with long, broken nails. Documentation review indicated that the resident's nails had not been trimmed during a one month period in 2012.
b) An identified resident was observed to have untrimmed nails on May 3, 2012 and dirty nails on May 28, 2012. Staff interview confirmed that nail care was to be provided with bathing on the resident's scheduled bathing days, and that the resident's nails were dirty during observation on May 28, 2012. Personal Support Workers interviewed refused to acknowledge that the resident's nails were dirty and acted to assist the resident with this hygiene only after the Assistant Director of Care provided direction.
c) The identified residents did not receive nail care weekly on bath day and as needed.

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 with ensuring that each resident of the home receives fingernail care, including the cutting of fingernails, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 44] Previously issued May 24, 2011 as a WN.
The licensee failed to ensure that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of residents.
An identified resident had an order for the use of a specific medication/supply to be used twice weekly. A review of the Medication Administration Record indicated that on two occasions, the resident did not receive the medication as ordered. On both dates, progress notes indicated the resident did not receive the medication as the supplies were not available in the facility. A negative outcome was experienced by the resident as a result of the lack of medical supplies. An additional treatment and an increase in oral treatment was ordered.
The home did not consistently have required supplies available to meet the personal care needs of the identified resident.

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 with ensuring that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following subsections:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 68(2)(a)]
The home's registered dietitian confirmed that consultation had not taken place in the development and implementation of some policies and procedures related to nutrition care and dietary services. The dietitian stated that the home did not have a policy developed and implemented for high energy high protein interventions at the time of the inspection. The food service manager and dietitian confirmed that some policies were revised January 2012 however, the home had not completed implementation.

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 with ensuring that the nutrition care and hydration programs include the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following subsections:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures;
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 34(1)(a)] Previously issued February 1, 2011 as a WN.
The licensee of the long term care home did not ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that included mouth care in the morning and evening, including the cleaning of dentures.
An identified resident did not receive oral care in the morning of May 28, 2012. The resident's morning care was completed and the resident was put back to bed, however, the personal support worker stated that oral care was not provided. The resident's oral care was not provided later in the morning when they got up and their toothbrush was dry and not used to provide oral care.

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 with ensuring that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, mouth care in the morning and evening, including the cleaning of dentures, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 24(1)2] Previously issued September 7, 2010 as a VPC; November 3, 2010 as a VPC.
The licensee did not ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may have occurred immediately reported the suspicion and the information upon which it was based to the Director.
Abuse of a resident by anyone that resulted in harm or risk of harm to the resident.
a) An identified resident reported a co-resident deliberately bumped into their wheelchair which resulted in injuries.
b) An identified resident reported that another resident struck them on the arm, which resulted in an injury.
c) The ADOC and DOC confirmed the incidents of abuse were not reported to the Director.

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 person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to the resident, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following subsections:

s. 24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 79/10, s. 24 (1).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 24(1)]
The licensee failed to ensure that a 24-hour admission care plan was developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home.
An identified resident was admitted to the home in 2012. A Kardex containing information related to the care required for the resident was not made available to staff until two days later. Staff interviewed confirmed that a copy of the Kardex is used to provide front line staff information found in the plan of care.

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 232. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home. O. Reg. 79/10, s. 232.

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 232]
The licensee did not ensure that the recreation records of the residents of the home were kept at the home.
Recreation participation records for each resident, used in the clinical assessment process, were not retained at the home after a three month period. The records were discarded and not maintained as part of the residents' clinical health records. Information related to resident participation for two identified residents could not be referenced prior to the three month period during this inspection.

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 32]
An identified resident did not receive individualized personal care, including hygiene care and grooming on a daily basis. The resident confirmed that shaving was not always completed by staff especially in difficult areas. Staff interviewed confirmed that the resident was not consistently shaved when required because it was difficult to do. The resident was not shaven on May 24, 25, 2012.

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following subsections:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 33(1)]
The licensee failed to ensure that an identified resident was bathed, twice a week by the method of their choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.
Documentation and interview confirmed that the resident did not receive a bath twice weekly throughout one identified month in 2012. The resident received scheduled baths on two days in the identified month. Interview identified that the resident refused bathing at times, and when this occurred the plan of care indicated family were to be involved to ensure that the resident received a bath twice weekly as identified in the homes policy and on the plan of care. Interview with the Director of Care identified the expectation, related to bathing, was that residents who refused would be offered a bath of their choice at alternative time. There was no documentation of the resident being offered a bath on an alternate day, shift or by an alternative means (e.g. sponge bath) or communication with the family related to the resident refusing their bath.

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. [O.Reg. 79/10, s.124]
The licensee did not ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, were obtained based on resident usage, and that no more than a three-month supply was kept in the home at any time. The home had the following quantities of drugs stored in the second floor drug room: The government pharmacy drug supply quantities exceeded a three month usage. Ten bottles containing 24 tablets per bottle of 50 mg dimenhydrinate, 10 bottles containing 97 tablets per bottle of 100mg dimenhydrinate, 33 bottles containing 100 tablets per bottle of biscodyl suppositories and 36 bottles containing 24 tablets per bottle of glycerin suppositories. The Director of Care confirmed the quantity of drugs stored exceeded the home's three-month usage.

WN #27: 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. [LTCHA, 2007, S.O. 2007, c.8, s.5] Previously issued July 28, 2010 as a CO.
The licensee did not ensure that the home was a safe and secure environment for every resident.
a) An identified resident stated on May 3, 2012 that they had requested the maintenance department assess concerns in their room on at least six occasions because the maintenance issues were causing injury to the resident. The inspector reported the resident's concern to the ADOC and registered staff. On May 5, 2012 the resident reported that the maintenance department had still not addressed their concerns. The inspector reported the issue to the DOC who paged maintenance, at which time action was finally taken.
b) On May 14, 2012 it was observed that the door to a resident room was difficult to open due to the weight of the door. It was also noted that when the door was not being held open it slammed shut with excessive force. Staff stated the door had been like this for some time, was very heavy and dangerous enough to cause injury. Staff indicated the concern had not been reported to maintenance. The door was brought to the attention of the senior management team on May 14, 2012; the door pin was adjusted by the maintenance department the same day.

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 228.3]
The licensee did not ensure that improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents were communicated to the Residents' Council and Family Council on an ongoing basis. The Administrator had not provided the Residents' Council and Family Council with the quality improvement and utilization review system results. This was confirmed by the President of the Residents' Council, the Chair of the Family Council, the Administrator, and the minutes of the meetings.

WN #29: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 67]
The Administrator of the home, President of the Residents' Council, and Chair of the Family Council confirmed that the licensee did not meet at least every three months with the Residents' and Family Councils. The President of the Residents' Council confirmed this was not done for over a year. The Administrator confirmed they had not met with the Residents' Council for over a year. The meeting minutes confirmed this had not occurred.

WN #30: 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 subsections:

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);
(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;
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and
(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. [LTCHA, 2007, S.O. 2007, c.8, s. 85(4)(a)]
The administrator had not provided the Family Council with the results of the satisfaction surveys, nor sought advice from the Family Council about the survey. The Administrator identified this had been provided, however the Family Council Chair and the minutes of the meetings do not support the information had been shared with the Family Council.
2. [LTCHA, 2007, S.O. 2007, c.8, s. 85(3)]
The Chair of the Family Council and minutes of the Family Council meetings confirmed the council had not been included in the development and implementation of the satisfaction survey, nor involved in the acting on the results.
3. [LTCHA, 2007, S.O. 2007, c.8, s. 85(3)]
The licensee did not seek the advice of the Residents' Council in developing and carrying out the satisfaction surveys, and in acting on its results. The President of the Residents' Council and the Administrator confirmed the results were shared with the council, however, the development of the survey was not done in consultation with the Residents' Council. The minutes of the meetings confirmed this was not done.

WN #31: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following subsections:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 101(1)3]
The licensee did not ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was responded to.
The Chair of the Family Council submitted a letter of complaint, regarding the operation of the home, to the C.E.O of Apans Health Services, Management Company acting on behalf of Grace Villa Ltd. in February 2012 and had not received a response. The Administrator confirmed a response had not been provided.

WN #32: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following subsections:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 22(1)]
The licensee did not ensure that when a written complaint concerning the care of a resident or the operation of the long-term care home was received, it was immediately forwarded to the Director.
The Chair of the Family Council submitted a written letter of complaint to the C.E.O. in February or March 2012 and the Director had not received a copy of the written complaint or the response to the complainant. The Administrator confirmed that the letter was received by the C.E.O. and Administrator, however, was not forwarded to the Director.

WN #33: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following subsections:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 57(2)]
When the Residents' Council advised the licensee of concerns or recommendations under either paragraph 6 or 8 or subsection (1), the licensee did not, within 10 days of receiving the advice, respond to the Residents' Council in writing.
The President of the Resident's Council, identified they had never received a response in writing from the Administrator regarding concerns or recommendations made by the council. The Residents' Council binder held by the President did not include copies of the required responses. The Administrator confirmed that they had not provided a written response to Residents' Council for over 1 year.

WN #34: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 30(2)] Previously issued February 1, 2011 as a WN; May 24, 2011 as a VPC.
The licensee did not ensure that actions taken with respect to an identified resident under the Recreation program, including an evaluation of the resident's response to interventions, were documented. Recreation staff confirmed that an evaluation of the resident's recreation programing goals and interventions and of the resident's plan of care was not documented at a quarterly review.
2. The licensee did not ensure that any actions taken with respect to an identified resident under the nutrition program, including assessments, reassessments, interventions and the resident's responses to interventions, were documented. Documentation in the resident's clinical health record indicated that a 3 day food and fluid intake study was initiated. A progress note completed by the home's dietitian indicated that a follow up on the resident's oral intake would be completed later in the week, however, there was no assessment of the food and fluid intake study documented by the dietitian and only 5/9 meals over the three day food study were documented.

WN #35: 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 subsections:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) an explanation of the duty under section 24 to make mandatory reports;
(e) the long-term care home's procedure for initiating complaints to the licensee;
(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;
(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;
(h) the name and telephone number of the licensee;
(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;
(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;
(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;
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge;
(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;
(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;
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package;
(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;
(q) an explanation of the protections afforded by section 26; and
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 78(2)(q)]
The admission package did not include an explanation of whistle-blowing protections related to retaliation. Staff confirmed that this information was not currently included in the admission package.
2. [LTCHA, 2007, S.O. 2007, c.8, s. 78(2)(g)]
The admission package did not include the home's policy on minimizing the restraining of residents and how to obtain a copy of the policy. Staff confirmed this information was not currently in the home's admission package.
3. [LTCHA, 2007, S.O. 2007, c.8, s. 78(2)(c)]
The admission package did not include the home's policy to promote zero tolerance of abuse and neglect of residents. Staff confirmed this information was not currently in the admission package.
4. [LTCHA, 2007, S.O. 2007, c.8, s. 78(2)(d)]
The admission package did not include an explanation of the duty to make mandatory reports related to incidents resulting in harm or risk of harm to a resident. Staff confirmed that this information was not included in the admission package.

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:

CORRECTED 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**
LTCHA, 2007 S.O. 2007, c.8 s. 6. (6)	CO #901	2012_066107_0008	107
LTCHA, 2007 S.O. 2007, c.8 s. 11.	CO #001	2011_066107_0002	107
O.Reg 79/10 r. 26.	CO #009	2011_066107_0002	165
O.Reg 79/10 r. 72.	CO #006	2011_066107_0002	107

Issued on this 29th day of August, 2012

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

M Wanner, RD