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 prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Oct 29, 2015;	2015_333577_0012 (A1)	011131-15	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET P.O. BOX 3251 THUNDER BAY ON P7B 5G7

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

HOGARTH RIVERVIEW MANOR
300 LILLIE STREET THUNDER BAY ON P7C 4Y7

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

DEBBIE WARPULA (577) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Change compliance date for Compliance order #001, #002, #003, #004 to October 19, 2015.

Issued on this 29 day of October 2015 (A1)

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

Original report signed by the inspector.

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

DEBBIE WARPULA (577) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): June 15, 16, 17, 18, 19, 22, 23, 24, 25 & 26, 2015

During the course of the inspection, the inspector(s) conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed the health care records for several residents, and reviewed numerous policies, procedures and programs.

During the course of the inspection, the inspector(s) spoke with Nurse Manager (s), RAI Coordinator, Food Services Supervisor, Registered Dietitian (RD), Dietary Staff, Life Enrichment Coordinator, Volunteer Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Family Members and Residents

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Critical Incident Response

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **16 WN(s)**
- **7 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 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 has failed to ensure that resident #025 was protected from abuse by S#102 and S#103.

On February 26, 2015, information was received by the Ministry of Health and Long-Term Care concerning staff to resident abuse. Inspector #597 reviewed the Critical Incident report which indicated that in February 2015, S#102 and S#103 were witnessed on video tape, to be talking in a demeaning manner, using foul language, and using physical force to get resident #025 to stand and lie back down in order to change their brief. The video camera was placed in the resident's room by the family and they reported the incident to the home in February 2015.

Inspector #597 spoke with the Power of Attorney of resident #025, who reported that they put the camera in the resident's room as they had brought concerns forward to the previous manager but had not received any response.

The personnel files of S#102 and S#103 were reviewed by inspector #597 and they noted that there were no previous incidents of discipline found in the staff member's files. On June 24 and 25, 2015, S#104, S#105, S#106 and S#107 were interviewed by inspector #597 regarding the incident in February 2015. Scheduling records indicated that those staff members worked on that day in February 2015 or frequently worked with S#102 and S#103. The staff interviewed were not able to identify any previous concerns regarding resident care that they had while working with S#102 or S#103.

On June 23 and 25, 2015, S#108, S#107 and S#109 were interviewed by inspector #597 regarding providing care to resident #025. If they approached the resident to provide care and they did not want to get up or seem to resist, they would just leave and reapproach. They further reported to the inspector that it is important to try and make sure that the resident understands staff directions.

Non-compliance has been previously issued under inspection 2012_104196_0026, including a compliance order served October 23, 2012; pursuant to LTCHA, 2007 S.O. 2007, 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.

The decision to re-issue this compliance order was based on the scope which affected one resident, the severity which indicates actual harm/risk and the compliance history including one compliance order previously issued in this area of the legislation. [s. 19. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that 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.

The personnel file of S#110 was requested by Inspector #597 and was reviewed on June 30, 2015. It was noted that the employee had received a letter of discipline in June 2015 for improper care of resident #011, not following specific SDM instructions, refusing to assist a staff member, and feeding residents #012, #013 and #014 incorrect diets.

S#111 was interviewed regarding the investigation of S#110. They reported that the complaints were brought forward by the co-workers of S#110 and that they had previously brought forward these concerns to the previous manager and no action was taken. They further reported that the home had not submitted a Critical Incident report to the Ministry of Health and Long Term Care as the allegations did not involve specific residents, were general observations of staff and the home had not received complaints from residents or families.

A copy of the email sent to the manager by S#112 was also reviewed in the personnel file. The email indicated that S#110 refused to turn resident #025, and did not follow family request to assist resident #022 into bed in the afternoon. During the home's investigation S#110 had admitted to not following the care plans and altering the diets of three specific residents.

The home had reasonable grounds to suspect that S#110 provided improper or incompetent treatment or care of a resident(s) that resulted in harm or a risk of harm to the resident yet a critical incident report was not submitted to the Director.

Non-compliance has previously been identified under inspection 2014_246196_0016 and 2012_104196_0026, including two Voluntary Plans of Correction/VPC; pursuant to LTCHA, 2007 S.O. 2007, 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.

The decision to issue this compliance order was based on the scope which affected four residents, the severity which indicates actual harm/risk and the compliance history including two voluntary plans of correction previously issued in this area of legislation. [s. 24. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

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

s. 6. (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 has failed to ensure that there is a written plan of care for residents #061, #010 and #004 that sets out clear directions to staff and others who provide direct care to the resident.

In October 2014, the Ministry of Health Long Term Care received information concerning responsive behaviours displayed by resident #061. On June 23, 2015, Inspector #603 interviewed resident #064 who reported that resident #061 would enter their room and attempt to get into their bed, sit on their chair, or go through their personal belongings. Resident #064 did not feel comfortable with resident #061 wandering into their room as they are not able to ring the call bell fast enough to prevent resident #061 from entering their room.

Inspector reviewed resident #061's care plan, which indicated a history of wandering behaviour. Their wanderguard was removed in February 2013, as behaviour was no longer present.

Inspector #603 reviewed resident #061's progress notes from October 2014. On a day in October 2014, resident #061 was found to be in co-resident's bed and on another day in October 2014, resident #061 was found laying in bed with another resident. During an interview, S#115 reported to the inspector that resident #061 wandered around the unit and needed to be redirected. [s. 6. (1) (c)]

2. In December 2014, resident #010 had a fall from their bed which resulted in a transfer to hospital where the resident suffered a significant injury.

On June 23, 2015, Inspector #577 reviewed resident #010's updated care plan post-fall, dated December 2014, to January 2015. Under the nursing focus, interventions indicated "all bed rails up at all times for safety and mobility, personal assistance services device (PASD), all bed rails to be up at all times for turning and repositioning in bed", under another focus, interventions indicated "two upper bed rails up and call bell within reach when in bed", under focus 'falls/balance' interventions included "ensure bed in lowest position, two upper bed rails up and call bell within reach when in bed".

The care plan did not provide clear directions concerning bed rails. [s. 6. (1) (c)]

3. Inspector #196 reviewed the current care plan for resident #004 for information regarding nutritional care needs. The first page of the care plan listed a nutritional supplement to be given four times daily with meals and offered at bedtime. On the second page of the care plan, under another nursing focus, the intervention included a different nutritional supplement to be given three times daily.

Two separate areas of the care plan identify a different type and administration frequency of supplement and therefore did not set out clear directions to staff who provide direct care to resident #004.

Non-compliances have been previously been issued under inspection 2012_104196_0026, including a Voluntary Plan of Correction and inspection 2014_246196_0016, including a Written Notification; pusuant to LTCHA, 2007 S.O. 2007, s. 6 (1)(c)Every licensee of a long-term care home shall 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.

The decision to issue this compliance order was based on the scope which affected three residents, the severity which indicates minimal harm/risk or potential for actual harm and the compliance history which indicated a VPC and a Written Notification. [s. 6. (1) (c)]

4. The licensee has failed to ensure that the care set out in the plan of care regarding positioning in their wheelchair due to altered skin integrity, is provided to resident #001 as specified in the plan.

On June 25, 2015, Inspector #577 reviewed resident #001's care plan which indicated that resident had altered skin integrity. Under a nursing focus, interventions indicated that resident will be up in their wheelchair for meals, for a short time and positioned comfortably and frequently in their bed and in wheelchair.

On June 24 and 25, 2015, Inspector #577 made frequent observations of resident #001, up in their wheelchair. On June 24, 2015, Inspector observed resident to be up in their wheelchair at 1100hr and remained in their wheelchair past 1620hr. On June 25, 2015, Inspector made the same observations. Inspector spoke with S#100 on June 25, 2015, who reported that resident is generally up in their wheelchair all day and goes back to bed after dinner and S#134, further reported that resident is up for breakfast, and staff will put them to bed at 1500hr or after supper, depending on what the staff wants. [s. 6. (7)]

5. During the inspection, inspector #577 reviewed resident #001's MDS data and care plan. It was found that the resident had altered skin integrity.

On June 24, 2015, Inspector #577 reviewed resident #001's physician orders dated January 2015, which indicated that a specific treatment was to be completed every

third day. The orders for February 2015, indicated a treatment was to be completed every 2-3 days, and as needed and further orders for February 2015 indicated a specific treatment every second day and as needed.

Inspector spoke with S#101 on June 19, 2015, who reported that resident #001's skin integrity worsened in February 2015.

On June 24, 2015, Inspector #577 reviewed resident #001's treatment records from December 2014, to April 2015.
Inspector noted the treatment was not completed as ordered on three occasions during the months that were reviewed:
-treatment was completed and then not completed for six days
-treatment was completed and then not completed for four days
-treatment was completed and then not completed for four days [s. 6. (7)]

6. The licensee has failed to ensure that resident's #001 and #010 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 change or care set out in the plan is no longer necessary.

During Stage 1 of this inspection resident #001 was indicated as requiring further information as they were hospitalized for a medical condition in February 2015.

On June 19, 2015, Inspector #577 reviewed resident #001's MDS data, which indicated that resident #001 was hospitalized for a medical condition in February 2015, and returned to the home five days later. Inspector reviewed resident #001's care plan and noted that the care plan was not updated to reflect resident's change in condition post-hospitalization. Archived care plan dated February 2015, was reviewed and under a nursing focus, it indicated a medical condition in February 2015. The nursing focus was updated to indicate the resident had a medical condition, but the care plan did not indicate any expected outcomes or interventions for staff to follow.

Inspector #577 spoke with S#101, who confirmed that resident #001's care plan was not updated to reflect a change in condition after hospitalization. They further confirmed that care plan was updated on March 18, 2015. [s. 6. (10) (b)]

7. Resident #001 was hospitalized in February 2015 and returned to the home 5 days later.

On June 22, 2015, Inspector reviewed resident #001's Minimum Data Set (MDS) dated February 24, 2015. The data indicated resident had altered skin integrity which worsened with hospitalization. On June 22, 2015, Inspector reviewed resident #001's care plan and noted that the care plan was not updated to reflect resident's change in condition post-hospitalization. Archived care plan dated February 2015, was reviewed and under a nursing focus, it indicated an infection, February 2015, altered skin integrity. The nursing focus was updated to indicate the resident had altered skin integrity, but the care plan did not indicate any expected outcomes or interventions for staff to follow.

Inspector #577 spoke with S#101, who confirmed that resident #001's care plan was not updated to reflect a change in condition after hospitalization. They further confirmed that the care plan was not updated until March 2015. [s. 6. (10) (b)]

8. On December 16, 2014, the Ministry of Health Long Term Care received information that indicated resident #010 had a fall and suffered a significant injury. In December 2015, resident had a specific treatment applied.

On June 23, 2015, Inspector #577 reviewed resident #010's care plan and noted that it was not updated to reflect the resident's significant injury after their fall. Inspector reviewed the archived care plan dated December 2014-January 2015, post fall, and the care plan did not indicate any reference to a significant injury in the interventions.

Inspector #577 spoke with S#101 on June 19, 2015, who confirmed that resident #010's care plan was not updated to reflect the resident's significant injury.

Non-compliances have been previously issued under inspection 2012_104196_0026, including a Voluntary Plan of Correction and 2013_104196_0001, including a Written Notification; pursuant to LTCHA, 2007 S.O. 2007, s. 6 (10) (b) 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 the resident's care needs change or care set out in the plan is no longer necessary.

The decision to issue this compliance order was based on the scope which affected three residents, the severity which indicates minimal harm and the compliance history which indicated a Voluntary Plan of Correction and a Written Notification previously issued in this area of legislation. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 003, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 003,004

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary, specifically in regards to residents #009, #002, #004, and #001's ambulation equipment and seat belts.

On June 16, 2015, Inspector #196 made observations of unclean ambulation equipment. Specifically, resident #009's wheelchair seat surface was unclean with food debris and resident #002's wheelchair seat belt was soiled. On June 16, 2015, Inspector #577 observed resident #001's wheelchair arms, cushion and wheels unclean, with food stains.

On June 19, 2015, Inspector #577 made further observations and found resident #009's wheelchair arms, cushion and wheels unclean with food stains, resident #002's wheelchair seat belt soiled with food stains and resident #001's wheelchair headrest, seat belt and wheels unclean with food debris.

On June 23, 2015, Inspector #577 spoke with S#135 who reported that the responsibility of cleaning resident equipment is assigned to night shift staff. They further reported that for every day of the month, a residents wheelchair and walker is cleaned. Inspector spoke with S#136 who also reported that night staff are responsible for cleaning residents wheelchairs and walkers. [s. 15. (2) (a)]

2. On June 16, 2015, the seat belt on resident #004's wheelchair was observed to be soiled. In addition, the seat belt was also soiled with food debris on June 23, 2015, and on June 24, 2015, the seat belt and the foot rest had food debris on it.

On three separate occasions, the seat belt on resident #004's wheelchair was observed to be soiled with food debris and was not cleaned as required. [s. 15. (2) (a)]

3. An interview was conducted with S#104 on June 25, 2015, and they reported that the cleaning of wheelchairs is done on the night shift, they are responsible for cleaning and there was no schedule to clean wheelchairs. [s. 15. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are kept clean and sanitary, specifically in regards to residents #001's, #002's, #004's and #009's ambulation equipment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, specifically regarding residents #010, #011, #012, #003 and #013.

On June 16, 2015, Inspector #577 observed resident #010, to be lying in bed and their call bell was on the floor. On June 25, 2015, resident #010 was lying in bed and their call bell was underneath their bed.

On June 16, 2015, resident #011 was lying in their bed and their call bell was on the floor.

On June 17, 2015, Inspector #577 observed resident #012 lying in bed and their call bell was on the floor.

On June 17 and 19, 2015, Inspector #577 observed resident #003 lying in bed and their call bell hanging off the bottom side rail near the floor.

On June 22, 2015, Inspector reviewed resident #003's care plan. Under a nursing focus, the interventions indicated "call bell within reach at all times".

On June 25, 2015, Inspector #577 observed resident #013 lying in bed and their call bell not within reach, hanging off the bottom of bed rail.

On five separate days, Inspector #577 observed four residents to be lying in their beds with their call bells on the floor or near the floor, out of residents' reach and not easily accessed by residents when they were in bed. [s. 17. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, specifically in regards to residents #003, #010, #011, #012 & #013, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that actions taken with respect to resident #022 and #024 under the Skin and Wound Care program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

The altered skin integrity record for resident #022 was reviewed by inspector #597 and it indicated that the resident was to receive a specific treatment every three days.

The Skin and Wound Care Program dated September 2012, indicated, "after a dressing change, registered nursing staff must complete the wound assessment tool. Weekly documentation includes size (circumference and depth) of the wound, discharge from the wound, appearance, progression, pain, nutrition and equipment being used".

The altered skin integrity record for the month of May and June 2015, were reviewed and the specific treatment had been signed for by registered staff as completed every three days for the months of May and June 2015, however the assessment of the altered skin integrity was not documented. Registered nursing staff had not completed this on any of the assessment categories and they were left blank on the record.

Inspector #597 reviewed the progress notes for altered skin integrity and only three entries were found between March 2015, and June 2015. [s. 30. (2)]

2. Resident #024 was admitted to the home in September 2014, with altered skin integrity. A census review completed indicated that currently the resident has altered skin integrity.

The altered skin integrity record for resident #024 was reviewed by inspector #597 which indicated a specific treatment.

The Skin and Wound Care Program dated September 2012, indicated that after a dressing change, registered nursing staff must complete the wound assessment tool. Weekly documentation includes size (circumference and depth) of the wound, discharge from the wound, appearance, progression, pain, nutrition and equipment being used.

The altered skin integrity record for the month of May and June 2015, was reviewed and the specific treatment had been signed for by registered staff on May 17, 19, 21, 23, 25, 27, 28, 31, and June 1, 2, 5, 6, 9, 11, 13, 15, 17, 20, 21, 2015, however the assessment was only documented on one day in June 2015. Registered nursing staff had only completed this information on one of the assessment categories.

The progress notes were reviewed by inspector #597 for altered skin integrity and only three entries were found May-June 2015. [s. 30. (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 any actions taken with respect to a resident under the Skin and Wound Care program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, specifically in regards to residents #022 and #024, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #010 fell, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #010 had a fall in December 2014, which resulted in a transfer to hospital and a significant injury.

On June 22, 2015, Inspector #577 reviewed resident #010's chart and could not locate a completed post fall assessment. Inspector spoke with S#101 who further confirmed through record review, that a post fall assessment was not completed for resident #010 for the fall in December 2014.

On June 24, 2015, Inspector reviewed the home's Falls Prevention Program. The policy indicates that after a fall, "a head to toe assessment is completed, initiates HIR for all unwitnessed falls and witnessed falls that have resulted in possible head injury, incident report, documents in progress note: date and time of incident, location, witnessed/unwitnessed, status of resident, assessments completed and outcome of assessment, who was notified of fall, probable cause of fall, resident outcomes and interventions taken to prevent further falls, and if resident was taken to the hospital. Completes a Post Fall Assessment". [s. 49. (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 when a resident falls, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, specifically in regards to resident #010, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: A change of 7.5 per cent of body weight, or more, over three months, specifically in regards to resident #004.

Resident #004 was admitted to the home in July 2014 and their weight was noted on admission. By June 5, 2015, resident had lost 10.9 kg.

An interview was conducted with S#116/Registered Dietician on June 24, 2015, and it was reported that they normally get an email about dietary concerns or a resident's weight from the registered staff or S#101. Unless the staff notify them, they may not be aware of the change until the next assessment is completed. S#116 also reported that usually 5% in one month or 7.5% in three months, 10% in six months, is considered to be a significant weight loss. In addition, they reported that resident #004 had lost 4.2% of body weight in the last 3 months, they were at a high nutrition risk and were provided with supplements for weight gain. S#116 reported that they had not been notified of the 13.8 % weight loss from October 2014 to December 2014.

When resident #004 had over a 7.5% per cent change in body weight over a three month period, they were not assessed using an interdisciplinary approach, specifically the RD was not notified of this change. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: A change of 7.5 per cent of body weight, or more, over three months, specifically in regards to resident #004, to be implemented voluntarily.

WN #9: 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:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences, in regards to nutritional supplements that were to be provided to residents #015 and #022.

On June 22, 2015, the dinner service was observed on one of the nursing units. Resident #015 and #022 were listed on the dietary reference sheet as residents to be provided with a daily nutritional supplement with their meal. The care plan for resident #015 indicated the intervention of providing the resident with a nutritional supplement as ordered, and on the front of the care plan it listed the nutritional supplement, three times a day added to coffee at meals. The care plan for resident #022 indicated under the supplement list a nutritional supplement to be given, three times a day added to one accepted meal item or an alternate nutritional supplement.

A Family member seated with resident #015 confirmed to the inspector that the nutritional supplement was not provided with the supper meal. S#136 confirmed that the nutritional supplement was not provided to resident #015 and #022.

During the supper meal, two residents were identified on the dietary reference sheet and in their respective care plans as requiring a nutritional supplement with the meal. The staff members assisting with the meal service were unaware of the residents' diets and special needs. [s. 73. (1) 5.]

2. The licensee has failed to ensure that resident #023 is provided with the personal assistance and encouragement required to safety eat and drink as comfortably and independently as possible.

Resident #023 was identified in Stage 1 as requiring further inspection due to weight loss based on record review. The resident's recorded weight in December 2014 was 61.8 kg and their recorded June 2015 weight was 54.6 kg.

The current care plan for resident #023 indicated that the resident was at risk for nutritional status due to medical issues and that their appetite varies from fair to good.

S#108 and S#107 reported that they were not aware of any concerns related to nutrition or feeding related to resident #023. They also reported that the resident was usually assisted with feeding by the volunteers at lunch and family at supper time.

S#108 reported that staff are supposed to serve the residents and the volunteers are to feed them, however the volunteers have been helping out with serving as well.

On June 19 and 22, 2015, resident #023 was observed in the dining room at the lunch service and S#118 was assisting the resident with eating. S#118 was also observed serving the food from the servery to residents' sitting at the table with resident #023.

Resident #023 was observed eating lunch in the dining room on June 24, 2015, and was fed by S#119. S#119 reported that they were hired by family of resident #016 to assist them to eat but also has assisted resident #023 since they returned from a hospital admission. S#119 states that they have had training in safe feeding of children. S#119 was also observed to be collecting the residents' meals from the servery before sitting down to assist them to eat. S#119 was also observed to be encouraging a resident to drink thickened soup from a glass. The resident was unable to drink the soup as it was too thick. S#119 did not bring this to the attention of staff and the resident was left waiting for the next course to be served.

On June 25, 2015, Inspector #597 spoke with S#120 who reported that all volunteers are screened by the home and attend orientation including safe feeding training and all volunteers in the dining room are "supervised" by the staff in the home and are to only feed one person at a time. They further reported that volunteer's do not feed "high risk" residents and described high risk as residents that have choking / swallowing concerns and that volunteers do not serve the residents, and that they rely on staff for direction regarding special diets and textures.

On June 25, 2015, Inspector #597 interviewed S#121 regarding volunteers in the dining room. They reported that volunteers were never assigned to residents with a choke risk, they are never to go to the servery to get food for the residents and nursing staff were responsible to ensure that residents receive the correct diet and texture. They further reported that S#118 was a registered volunteer with the home, however S#119 was hired privately by the family of resident #016.

S#111 was interviewed on June 24, 2015, and reported that they were aware that volunteers were assisting residents to eat on a nursing unit. They further reported that they were not aware that a volunteer was assisting resident #023, whose care plan indicated that they have medical issues. [s. 73. (1) 9.]

3. The licensee has failed to ensure that residents who required assistance with eating or drinking is served a meal until someone is available to provide the assistance

required by the resident, specifically in regards to residents #012 and #013.

On June 22, 2015, during the dinner service, inspector #196 observed residents #013 and #012 seated at their respective dining tables in specialized chairs with a plate of food in front of them at 1703hr and staff were not available to assist. At 1710hr, S#136 was observed to start assisting resident #013 and S#108 assisted resident #012. The kardex for both residents were reviewed by the inspector and they identified the need for assistance of staff with their meals.

Residents #013 and #012 were not provided with staff assistance at the time of being served their dinner meal on June 22, 2015. [s. 73. (2) (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 that the home has a dining and snack service that includes, at a minimum, the following elements: A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences, specifically in regards to resident #015 & #022; residents are provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, specifically in regards to resident #023; and that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, specifically in regards to residents #012 & #013, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act: That the resident's condition was reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances, specifically for resident #004.

Resident #004 was observed to have a front closing seat belt in place on June 23, 2015.

The electronic MAR documentation regarding the reassessment of the use of the seat belt restraint was reviewed. The resident's condition and the effectiveness of the restraining was documented by the registered staff every 12 hours, at 0800 and 2000hr from June 1, 2015, to June 22, 2015 and not every 8 hours as required. [s. 110. (2) 6.]

2. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act, the following was documented, every release of the device and all repositioning, specifically for resident #004.

On June 23, 2015, resident #004 was observed seated in a chair with a front closing seat belt in place. Inspector asked the resident if they were able to unfasten the seat belt and they reported that they couldn't.

An interview was conducted with S#104 on June 25, 2015, and they reported that resident #004 had a new wheelchair with a seat belt and that the resident was unable to unfasten the seat belt. S#114 also reported that this resident had a front facing seat belt in place and they were unable to unfasten it.

The health care record for resident #004 was reviewed for information regarding the use of a seat belt restraint. The Registered Nurse/Extended Class order dated June 22, 2015, indicated "Front facing seat belt for resident safety reassess 3 months and as needed". The restraint monitoring sheet for month of June 2015, was copied and reviewed. Over a 24 day period in June 2015, from June 1 through to 24th, it was recorded that the resident had the front facing seat belt applied on the day shifts and evening shifts, removed later in the evening and not used during the night shift and on only three days had any repositioning or release of the restraint documented on this form.

The release and all repositioning of resident #004's front closing seat belt was not consistently documented on the restraint monitoring form. [s. 110. (7) 7.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following requirements are met where a resident is being restrained by a physical device, that the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances, specifically in regards to resident #004; and the use of restraints including all assessment, reassessment and monitoring, including the resident's response is documented, specifically in regards to resident #004, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan,(a) provided for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; (b) set out the organization and scheduling of staff shifts; (c) promoted continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; (d) included a back-up plan for nursing and personal care staffing that addressed situations when staff, including the staff who must provide the nursing coverage cannot come to work.

An interview was conducted with S#123 on June 24, 2015, regarding the written staffing plan for the home. A copy of the home's current staffing plan, #LTC 1-1- titled "Staffing Plan for Nursing and Personal Support Services" with approval date of September 2013, was provided and reviewed and did not include a back up plan for nursing and personal care staffing nor the organization and scheduling of staff shifts. [s. 31. (3)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality, specifically in regards to using food to thicken up the consistency of some foods.

On April 27, 2015, the Ministry of Health Long Term Care received information about the home's method of food being thickened up for puree diets. Concerns were specific regarding staff using cut up bread slices or bread crumbs to thicken up puree meals, mashed potatoes to thicken up meats, vegetables, soups and desserts. "Thicken Up", is a brand of thickener that is used for both food and liquids and was being used for fluids only.

On June 24, 2015, Inspector spoke with S#124, who reported that in June 2014, S#125/Food Services Supervisor gave direction to staff to use cut up bread slices or bread crumbs to thicken purees, mashed potatoes to thicken meats, vegetables, soups and desserts, and "Thicken Up" was used for fluids only. Inspector also spoke with S#126 on June 24, 2015, who indicated that there were memos posted for a year, giving direction to not use "Thicken Up" to change consistency of food. Both staff members voiced concerns about adding starches and possible choking potential. They further reported that staff are using "Thicken Up" now, except for dinner time and concerns about residents who cannot have bread products. Inspector reviewed a copy of the memo, which read, "Thicken Up" is used for fluids only! It is not used to thicken food items, any questions please ask me!!", signed by S#125.

Inspector #577 spoke with s#116/Registered Dietitian, who reported that S#125 preferred that staff use food to thicken up food. S#116 reports "Thicken Up" is a cornstarch and is starch based and reported they also prefer food to be thickened with food and that it's better to use food first before using "Thicken Up".

Inspector #577 spoke with S#128/Food Services Supervisor, who reported that there isn't a policy or guideline on thickening foods. They reported staff are to use "Thicken Up" for all foods to thicken for consistency and that staff have been trained on this. They further reported that food should be used to thicken ham and ground beef. Inspector informed them of previous direction to staff by S#125 and posted memo. They reported they were not aware and would direct staff to use "Thicken Up". [s. 72. (3) (a)]

WN #13: The Licensee has failed to comply with LTCHA, 2007, 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that they sought 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.

On June 23, 2015, Inspector #577 spoke with S#121 who reported that satisfaction survey results are presented to the council by the Research Department, but the home does not seek the advice of the council in developing and carrying out the satisfaction survey and acting on its results. [s. 85. (3)]

WN #14: 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. (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. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every verbal complaint made to the licensee or a staff member concerning the care of a resident was investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, specifically in regards to resident #005.

On June 17, 2015, resident #005 reported missing money to Inspector #597. Resident reported two incidents occurring four and six weeks ago, where approximately $280 dollars. They further reported that they told staff, their money was still missing and no-one had followed up with them.

Inspector spoke with the Nurse Manager, who reported they were not aware of resident #005's missing money. Inspector requested to see the home's policy for resident missing belongings/complaints.

On June 25, 2015, Inspector #577 reviewed home's policy on 'Service Complaints', dated April 2009. The policy stated that service complaints are dealt with in a prompt, courteous, fair and positive manner. A complainant is acknowledged within 24 routine or business hours and receives a written or verbal response within ten working days, unless the urgency attached to the matter requires an earlier response. Procedure for verbal complaints: The Manager is responsible for the investigation, resolution and responding back to the complainant within ten working days. Managers document the complaint and their follow-up on the Service Complaint Follow up Form. If the Manager is not contacted, staff documents the complaint, on a Service Complaint Follow-up Form and forwards to the Manager. The Manager is responsible to acknowledge within 24 hrs receipt of the complaint to the complainant and for investigation, resolution and responding back to the complainant within ten working days.

On June 25, 2015, Inspector #577 spoke with S#129, who reported that for missing resident belongings, staff would do a search for the item and then report it to a Manager. Inspector spoke with S#107, who reported they would search the unit for missing belongings, look in lost and found and talk to registered staff. S#104 reported that they would search the unit, talk to the Manager, tell other staff and document in a progress note. [s. 101. (1) 1.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,

i. a breakdown or failure of the security system,

ii. a breakdown of major equipment or a system in the home,

iii. a loss of essential services, or

iv. flooding.

O. Reg. 79/10, s. 107 (3).

3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of the incident of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, specifically in regards to resident #067.

On November 12, 2014, information was received by the MOHLTC concerning a resident fall with a significant injury.

The Critical Incident report indicated that in November 2014, resident #067 fell and was sent to the hospital for further assessment. That same day, the home was informed by the hospital that the resident had sustained a significant injury. The incident was not reported to the Director until five days later.

On June 9, 2015, information was received by the MOHLTC concerning a resident fall with a significant injury.

The Critical Incident report indicated that in June 2015, resident #067 fell and was sent to the hospital for further assessment. The following day, the home was informed by the POA that the resident had sustained a significant injury.

On June 25, 2015, Inspector #603 interviewed S#130 who reported that the critical incident occurring in June 2015, was reported late because they had not pressed submit, when doing the report on line.

On June 23, 2015, Inspector #603 interviewed S#137 who explained that once a critical incident is identified, the staff reports this to management through a patient safety report on the computer system. This report goes directly to the unit's manager.

On June 25, 2015, Inspector #603 reviewed the home's procedure "Safety Reporting of Client Incidents and Good Catches" and it did not refer to reporting to the MOHLTC's Director. S#132 could not find any other home policy around reporting critical incidents.

The home failed to inform the Director within one business day of two falls that resulted in significant injury to the resident, specifically concerning resident #067. [s. 107. (3)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During a walk through tour of one of the unit's on June 15, 2015, inspector #196 observed a resident care cart located outside of a resident room and there were no staff observed in the vicinity. On the top of the cart was a plastic bin with several plastic bags containing prescription ointments and creams labelled with resident names.

Inspector asked S#133 about the medications on the resident care cart and they reported that they should not have left it unattended in the hallway.

Medications were not stored in an area that was secure and locked and were accessible to anyone in the resident care area. [s. 129. (1) (a) (ii)]

Issued on this 29 day of October 2015 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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SUDBURY, ON, P3E-6A5
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : DEBBIE WARPULA (577) - (A1)

Inspection No. / No de l'inspection : 2015_333577_0012 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 011131-15 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Oct 29, 2015;(A1)

Licensee / Titulaire de permis :

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET, P.O. BOX 3251,
THUNDER BAY, ON, P7B-5G7

LTC Home / Foyer de SLD :

HOGARTH RIVERVIEW MANOR
300 LILLIE STREET, THUNDER BAY, ON,
P7C-4Y7

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Meaghan Sharp

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To ST. JOSEPH'S CARE GROUP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 ensure that resident #025 is protected from abuse by anyone.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #025 was protected from abuse by S#102 and S#103.

On February 26, 2015, information was received by the Ministry of Health and Long-Term Care concerning staff to resident abuse. Inspector #597 reviewed the Critical Incident report which indicated that in February 2015, S#102 and S#103 were witnessed on video tape, to be talking in a demeaning manner, using foul language, and using physical force to get resident #025 to stand and lie back down in order to change their brief. The video camera was placed in the resident's room by the family and they reported the incident to the home in February 2015.

Inspector #597 spoke with the Power of Attorney of resident #025, who reported that they put the camera in the resident's room as they had brought concerns forward to the previous manager but had not received any response.

The personnel files of S#102 and S#103 were reviewed by inspector #597 and they noted that there were no previous incidents of discipline found in the staff member's files. On June 24 and 25, 2015, S#104, S#105, S#106 and S#107 were interviewed by inspector #597 regarding the incident in February 2015. Scheduling records indicated that those staff members worked on that day in February 2015 or frequently worked with S#102 and S#103. The staff interviewed were not able to identify any previous concerns regarding resident care that they had while working with S#102 or S#103.

On June 23 and 25, 2015, S#108, S#107 and S#109 were interviewed by inspector #597 regarding providing care to resident #025. If they approached the resident to provide care and they did not want to get up or seem to resist, they would just leave and reapproach. They further reported to the inspector that it is important to try and make sure that the resident understands staff directions.

Non-compliance has been previously issued under inspection 2012_104196_0026, including a compliance order served October 23, 2012; pursuant to LTCHA, 2007 S.O. 2007, 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.

The decision to re-issue this compliance order was based on the scope which affected one resident, the severity which indicates actual harm/risk and the compliance history including one compliance order previously issued in this area of the legislation. [s. 19. (1)]
(597)

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

Oct 19, 2015(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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, s. 24 (1), 195 (2).

Order / Ordre :

The licensee shall ensure that a person who has reasonable grounds to suspect improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident has occurred or may occur, shall immediately report the suspicion and the information upon which it is based to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that 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.

The personnel file of S#110 was requested by Inspector #597 and was reviewed on June 30, 2015. It was noted that the employee had received a letter of discipline in June 2015 for improper care of resident #011, not following specific SDM

instructions, refusing to assist a staff member, and feeding residents #012, #013 and #014 incorrect diets.

S#111 was interviewed regarding the investigation of S#110. They reported that the complaints were brought forward by the co-workers of S#110 and that they had previously brought forward these concerns to the previous manager and no action was taken. They further reported that the home had not submitted a Critical Incident report to the Ministry of Health and Long Term Care as the allegations did not involve specific residents, were general observations of staff and the home had not received complaints from residents or families.

A copy of the email sent to the manager by S#112 was also reviewed in the personnel file. The email indicated that S#110 refused to turn resident #025, and did not follow family request to assist resident #022 into bed in the afternoon. During the home's investigation S#110 had admitted to not following the care plans and altering the diets of three specific residents.

The home had reasonable grounds to suspect that S#110 provided improper or incompetent treatment or care of a resident(s) that resulted in harm or a risk of harm to the resident yet a critical incident report was not submitted to the Director.

Non-compliance has previously been identified under inspection 2014_246196_0016 and 2012_104196_0026, including two Voluntary Plans of Correction/VPC; pursuant to LTCHA, 2007 S.O. 2007, 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.

The decision to issue this compliance order was based on the scope which affected four residents, the severity which indicates actual harm/risk and the compliance history including two voluntary plans of correction previously issued in this area of legislation. [s. 24. (1)]
(597)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Oct 19, 2015(A1)

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure that the written plans of care for residents #004, #010 and #061 sets out clear directions to staff and others who provide direct care to the residents.

Grounds / Motifs :

1. The licensee has failed to ensure that there is a written plan of care for residents #061, #010 and #004 that sets out clear directions to staff and others who provide direct care to the resident.

In October 2014, the Ministry of Health Long Term Care received information concerning responsive behaviours displayed by resident #061. On June 23, 2015, Inspector #603 interviewed resident #064 who reported that resident #061 would

enter their room and attempt to get into their bed, sit on their chair, or go through their personal belongings. Resident #064 did not feel comfortable with resident #061 wandering into their room as they are not able to ring the call bell fast enough to prevent resident #061 from entering their room.

Inspector reviewed resident #061's care plan, which indicated a history of wandering behaviour. Their wanderguard was removed in February 2013, as behaviour was no longer present.

Inspector #603 reviewed resident #061's progress notes from October 2014. On a day in October 2014, resident #061 was found to be in co-resident's bed and on another day in October 2014, resident #061 was found laying in bed with another resident. During an interview, S#115 reported to the inspector that resident #061 wandered around the unit and needed to be redirected. [s. 6. (1) (c)]

2. In December 2014, resident #010 had a fall from their bed which resulted in a transfer to hospital where the resident suffered a significant injury.

On June 23, 2015, Inspector #577 reviewed resident #010's updated care plan post-fall, dated December 2014, to January 2015. Under the nursing focus, interventions indicated "all bed rails up at all times for safety and mobility, personal assistance services device (PASD), all bed rails to be up at all times for turning and repositioning in bed", under another focus, interventions indicated "two upper bed rails up and call bell within reach when in bed", under focus 'falls/balance' interventions included "ensure bed in lowest position, two upper bed rails up and call bell within reach when in bed".

The care plan did not provide clear directions concerning bed rails. [s. 6. (1) (c)]

3. Inspector #196 reviewed the current care plan for resident #004 for information regarding nutritional care needs. The first page of the care plan listed a nutritional supplement to be given four times daily with meals and offered at bedtime. On the second page of the care plan, under another nursing focus, the intervention included a different nutritional supplement to be given three times daily.

Two separate areas of the care plan identify a different type and administration frequency of supplement and therefore did not set out clear directions to staff who provide direct care to resident #004.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Non-compliances have been previously been issued under inspection 2012_104196_0026, including a Voluntary Plan of Correction and inspection 2014_246196_0016, including a Written Notification; pusuant to LTCHA, 2007 S.O. 2007, s. 6 (1)(c)Every licensee of a long-term care home shall 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.

The decision to issue this compliance order was based on the scope which affected three residents, the severity which indicates minimal harm/risk or potential for actual harm and the compliance history which indicated a VPC and a Written Notification. [s. 6. (1) (c)]

(196)

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

Oct 19, 2015(A1)

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall ensure that written plans of care for residents #010 and #001 are reviewed and revised at least every six months and whenever their care needs change or care set out in the plan is no longer necessary.

Grounds / Motifs :

1. The licensee has failed to 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, (b) the resident's care needs change or care set out in the plan is no longer necessary; 2007, c. 8, s. 6 (10).

The licensee has failed to ensure that the care set out in the plan of care regarding positioning in their wheelchair due to altered skin integrity, is provided to resident #001 as specified in the plan.

On June 25, 2015, Inspector #577 reviewed resident #001's care plan which indicated that resident had altered skin integrity. Under a nursing focus, interventions indicated that resident will be up in their wheelchair for meals, for a short time and positioned comfortably and frequently in their bed and in wheelchair.

On June 24 and 25, 2015, Inspector #577 made frequent observations of resident #001, up in their wheelchair. On June 24, 2015, Inspector observed resident to be up in their wheelchair at 1100hr and remained in their wheelchair past 1620hr. On June 25, 2015, Inspector made the same observations. Inspector spoke with S#100 on June 25, 2015, who reported that resident is generally up in their wheelchair all day and goes back to bed after dinner and S#134, further reported that resident is up for breakfast, and staff will put them to bed at 1500hr or after supper, depending on what

the staff wants. [s. 6. (7)]

5. During the inspection, inspector #577 reviewed resident #001's MDS data and care plan. It was found that the resident had altered skin integrity.

On June 24, 2015, Inspector #577 reviewed resident #001's physician orders dated January 2015, which indicated that a specific treatment was to be completed every third day. The orders for February 2015, indicated a treatment was to be completed every 2-3 days, and as needed and further orders for February 2015 indicated a specific treatment every second day and as needed.

Inspector spoke with S#101 on June 19, 2015, who reported that resident #001's skin integrity worsened in February 2015.

On June 24, 2015, Inspector #577 reviewed resident #001's treatment records from December 2014, to April 2015.
Inspector noted the treatment was not completed as ordered on three occasions during the months that were reviewed:
-treatment was completed and then not completed for six days
-treatment was completed and then not completed for four days
-treatment was completed and then not completed for four days [s. 6. (7)]

6. The licensee has failed to ensure that resident's #001 and #010 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 change or care set out in the plan is no longer necessary.

During Stage 1 of this inspection resident #001 was indicated as requiring further information as they were hospitalized for a medical condition in February 2015.

On June 19, 2015, Inspector #577 reviewed resident #001's MDS data, which indicated that resident #001 was hospitalized for a medical condition in February 2015, and returned to the home five days later. Inspector reviewed resident #001's care plan and noted that the care plan was not updated to reflect resident's change in condition post-hospitalization. Archived care plan dated February 2015, was reviewed and under a nursing focus, it indicated a medical condition in February 2015. The nursing focus was updated to indicate the resident had a medical condition, but the care plan did not indicate any expected outcomes or interventions

for staff to follow.

Inspector #577 spoke with S#101, who confirmed that resident #001's care plan was not updated to reflect a change in condition after hospitalization. They further confirmed that care plan was updated on March 18, 2015. [s. 6. (10) (b)]

7. Resident #001 was hospitalized in February 2015 and returned to the home 5 days later.

On June 22, 2015, Inspector reviewed resident #001's Minimum Data Set (MDS) dated February 24, 2015. The data indicated resident had altered skin integrity which worsened with hospitalization. On June 22, 2015, Inspector reviewed resident #001's care plan and noted that the care plan was not updated to reflect resident's change in condition post-hospitalization. Archived care plan dated February 2015, was reviewed and under a nursing focus, it indicated an infection, February 2015, altered skin integrity. The nursing focus was updated to indicate the resident had altered skin integrity, but the care plan did not indicate any expected outcomes or interventions for staff to follow.

Inspector #577 spoke with S#101, who confirmed that resident #001's care plan was not updated to reflect a change in condition after hospitalization. They further confirmed that the care plan was not updated until March 2015. [s. 6. (10) (b)]

8. On December 16, 2014, the Ministry of Health Long Term Care received information that indicated resident #010 had a fall and suffered a significant injury. In December 2015, resident had a specific treatment applied.

On June 23, 2015, Inspector #577 reviewed resident #010's care plan and noted that it was not updated to reflect the resident's significant injury after their fall. Inspector reviewed the archived care plan dated December 2014-January 2015, post fall, and the care plan did not indicate any reference to a significant injury in the interventions.

Inspector #577 spoke with S#101 on June 19, 2015, who confirmed that resident #010's care plan was not updated to reflect the resident's significant injury.

Non-compliances have been previously issued under inspection 2012_104196_0026, including a Voluntary Plan of Correction and

2013_104196_0001, including a Written Notification; pursuant to LTCHA, 2007 S.O. 2007, s. 6 (10) (b) 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 the resident's care needs change or care set out in the plan is no longer necessary.

The decision to issue this compliance order was based on the scope which affected three residents, the severity which indicates minimal harm and the compliance history which indicated a Voluntary Plan of Correction and a Written Notification previously issued in this area of legislation. [s. 6. (10) (b)]

(577)

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

Oct 19, 2015(A1)

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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
Toronto ON M5S 2B1
Télécopieur : 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 29 day of October 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DEBBIE WARPULA - (A1)

Service Area Office /
Bureau régional de services : Sudbury