Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 24, May 13, 2014	2014_237500_0005	T-45-14	Resident Quality Inspection

Licensee/Titulaire de permis

UKRAINIAN HOME FOR THE AGED
767 Royal York Rd., TORONTO, ON, M8Y-2T3

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

IVAN FRANKO HOME
767 Royal York Road, TORONTO, ON, M8Y-2T3

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

NITAL SHETH (500), TILDA HUI (512), VALERIE PIMENTEL (557)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 24, 25, 26, 27, 28, March 4, 5, 6, 7, and 10, 2014.

During the course of the inspection, the inspector(s) spoke with the administrator, assistant administrator (AA), acting director of care (DOC), food service manager, physiotherapist, maintenance lead, infection prevention and control nurse, registered nursing staff, activation aide, personal support workers (PSW), house keeping staff, laundry attendant, residents and substitute decision makers.

During the course of the inspection, the inspector(s) conducted observations and record reviews.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

On February 24, 2014, the inspector observed four identified rooms to have windows that can open more than 15 centimetres, which might be a safety concern for residents. [s. 16.]

Additional Required Actions:

CO # - 901, 902 were served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

Observation conducted on an identified day, at lunch time, revealed that residents' personal health information including residents' names, diets, and textures were posted on an identified floor servery cart. This could be easily accessed by anyone who enters to the dining area.

The food service manager confirmed that the information posted on an identified floor servery cart is considered resident's personal health information. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential on the third floor servery cart in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

A record review revealed that on the night of an identified day resident #531 was found on the floor beside his/her bed and the bed alarm was not turned on. The resident’s plan of care did not identify in the falls prevention interventions the bed alarm.

An interview with the registered nursing staff confirmed the resident’s plan of care identified that the resident was to have a bed alarm in place when the resident is in bed and confirmed the resident had a bed alarm in place and it was not turned on, the night the resident had a fall. [s. 6. (1) (c)]

2. Record review of resident #531’s progress notes for an identified period revealed that the resident received an identified drug at night. Medication administration record indicated use of this medication every four hours when required and did not indicate the reason for use. The physician order did not include reason for use of the medication.

Resident #531's plan of care did not identify an assessment, goal and interventions to address the use of medications in response to identified responsive behaviours. [s. 6. (1) (c)]

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

On February 24, 2014, at 12:00 p.m., on an identified floor dining room the inspector observed that resident #001,#002, and #003 were served with half glass (60 ml) of nutritional supplements.

Record review of the residents’ plans of care revealed that the above identified residents should have been provided with full glass (125 ml) of nutritional supplements at lunch time.

An interview with the food service manager confirmed that the above mentioned residents were to receive 125 ml of supplements at lunch time. [s. 6. (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 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 and care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they are not being supervised by staff.

Observation conducted on March 6, 2014, revealed that residents have access to the basement by the elevator without restrictions. The doors of the carpentry room, electrical room and sprinkler room containing equipment were observed closed but unlocked without staff present.

An interview with the acting DOC confirmed that there were residents’ programs that occur in the basement congregate area, and to ensure residents’ safety, that the above mentioned doors of the service rooms should be kept locked at all times. [s. 9. (1) 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 all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #5: 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:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

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).

Findings/Faits saillants :

1. The licensee failed to ensure that where a resident is being restrained by a physical device, staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

On On February 25, 2014, resident #494 and #501 were observed in wheelchairs with seat belts engaged. The residents were not able to undo the seat belts when requested.

On March 7, 2014, resident #480 was observed sitting in a tilt wheelchair greater than 45 degree backward from sitting upright position in the small dining/activity room.

Staff interviews confirmed that residents #494 and #501 did not usually had the seat belts on and denied that the residents required restraints. Staff confirmed that resident #480 was in a tilt wheelchair but did not recognize it as a form of restraint.

Record review of the residents' plan of care and physician orders revealed that there were no orders for the restraints. [s. 110. (2) 1.]

2. The licensee failed to ensure that where a resident is being restrained by a physical device, 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.

Record review of the restraint records of three identified residents, #003, #004,and #005, revealed that the reassessment of the residents' condition and the effectiveness of the seat belt in the wheel chairs were not being conducted by 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.

An interview with acting DOC confirmed the reassessments were not being conducted by registered nursing staff, as the nursing department was not aware that residents' condition had to be reassessed and the effectiveness of the restraints evaluated by a member of the registered nursing staff, at least every eight hours. [s. 110. (2) 6.]

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 where a resident is being restrained by a physical device, staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that steps are taken to ensure the security of the drug supply, including all areas where drugs are stored to be kept locked at all times, when not in use.

The inspector observed on February 27, and on March 5, 2014, that the door to medication room on two identified floors were open with no registered nursing staff present.

An interview with the acting DOC and registered nursing staff confirmed that the doors to the medication rooms should be locked at all times when no registered nursing staff is present in the rooms. [s. 130. 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 steps are taken to ensure the security of the drug supply, including all areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's following policies are complied with.

The home’s policy titled Falls Prevention and Management #NM-1-042 dated May 2011, item B 1 for Fall and Post Fall Assessment and Management under Registered Nursing Staff stated that: “Initiate head injury routine (HIR) for all unwitnessed falls and witnessed falls that have resulted in a possible head injury”.

Record review revealed that head injury routine (HIR) was not initiated on an identified day for resident #478, who had an unwitnessed fall.

Interview with the acting DOC confirmed that HIR has not been initiated for the resident after the fall. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that the home's pre-employment screening policy on staff tuberculosis screening was complied with.

The home's policy titled Pre-employment Screening, ADM-HR, dated last revision on December 2013, revealed that a TB skin test or chest x-ray with negative results shall be completed pre-employment within one year.

Record review revealed that an identified staff member hired on an identified day, with positive TB skin test had negative chest x-ray report three weeks after employment had commenced. [s. 8. (1)]

3. A record review of the home's policy NM-1-14 titled Urinary & Bowel Continence Screening Program dated May 2011, revealed that "obtaining a 7 day bladder and bowel record was a requirement which will allow staff to assess bladder and bowel function of newly admitted residents". This requirement in the home's policy was not complied with.

An interview with a registered nursing staff revealed that new residents were monitored for three days after admission for continence pattern, if they require toileting plan or brief use.

The homes policy Medical Directives NM-A-073 revision date November 2012, indicates "medical directives or orders for the administration of a drug to a resident may be used only when it is individualized to the resident's condition and needs. All medical directives or orders for the administration of a drug to a resident will be reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care".

Record review and staff interviews confirmed that the physician had not selected initialed, signed and dated residents' medical directives. The registered nursing staff, when processing a medical directive did not place time, reason or effectiveness of the medications, and did not identify the order was only valid for 24 hours on the MAR. [s. 8. (1) (a),s. 8. (1) (b)]

4. A record review of the home's policy NM-I-020 titled Continence Care and Bowel Management Program- Policy and Procedures revision May 2011, revealed that "interdisciplinary, individualized continence care plan based on resident preferences and assessed needs will be developed for each resident to maximize independence, comfort and dignity and reviewed quarterly or after any change in condition which affects continence".

For resident #494 the Bladder and Bowel Continence Assessment tool was not completed as identified in the policy.

An interview with the registered nursing staff and record review confirmed that the above mentioned policy was not complied with for resident #494. [s. 8. (1) (a),s. 8. (1) (b)]

5. The home policy NM-I-024 titled Medication Review dated September 2013, and West End Pharmacy policy titled Three-Month Physician Medication Review, amended March 2011 revealed that any medication orders previous to the three month physician's medication review are to be discontinued.

Record review revealed that resident #011's three month drug review was completed by the physician on an identified day. One of the orders, was changed on the physicians order sheets. This order was not transcribed onto the three month physicians medication review and was not corrected to reflect the change.

Interviews with the acting DOC and registered nursing staff confirmed that the registered nursing staff did not check the three months drug review once signed by the physician and the identified order was not discontinued. [s. 8. (1) (a),s. 8. (1) (b)]

6. A review of the home's policy NM-I-211 titled Restraints - Physical revision date January 2012, revealed that "the decision to apply or reapply a physical restraint shall be evaluated prior to each application. There must be a written physician order unless it is an emergency situation. Decision to apply the restraint is to be made with resident or substitute decision maker and risks identified and that hourly checks to monitor the residents safety, comfort and positioning. Consent to Use Restraint (no form number), Assessed Reason for Physical Restraint NM-I-210(b), Restraint Assessment Alternatives to Restraint Use NM-I-210(a) and Physical Restraint Monitoring Record forms must be completed".

Observation on February 25, 2014, revealed that resident #494 was sitting in his/her wheelchair with a seat belt engaged.

A record review revealed that the resident's seat belt was not ordered by the physician and the registered nursing staff did not complete any pertaining assessments for the use of restraint.

An interview with the resident confirmed that the resident cannot undo the seat belt by him/herself.

Staff interviews confirmed that there was no physician order for the seat belt and the seat belt should not have been applied to the resident. [s. 8. (1) (a),s. 8. (1) (b)]

7. A review of the homes policy NM-I-042 titled Falls Prevention and Management Program revision date May 2011, revealed that "Initiate Head Injury Routine (HIR) for all unwitnessed falls and witnessed falls that have resulted in a possible head injury. Policy for Head Injury Routine NM-I-262 revision date March 2012, indicates that resident requires close observation for 24 - 48 hours and Form # Nursing-2009 Neurological Observation Record should be completed".

Resident #531 had a fall on an identified day. The registered nursing staff did not initiate HIR protocol after the resident's unwitnessed fall. The resident was not placed on a Neurological Observation Record and consistent monitoring for 24-48 hours as per policy.

Interviews with the registered nursing staff confirmed that a HIR is not completed unless the resident had evidence of hitting his/her head, therefore Neurological Observation Record was not initiated.

Medication Administration NM-I-028 revision date March 2013, indicates "medication cart is to be in the registered staff's line of vision at all times and must be locked when nurse cannot see the cart.

Narcotics and controlled drugs are to be counted by two registered staff (one come on shift and one going off shift) and recorded on appropriate form".

Observation conducted on February 28, March 4 and 5, 2014, revealed the medication cart was left unlocked and no registered nursing staff present. Two identified controlled substances for resident #531, #530 and #007 were found in their individualized medication bins. These controlled substances were not counted.

An interview with the acting DOC confirmed that the home did not count these controlled substances. [s. 8. (1) (a),s. 8. (1) (b)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that without restricting the generality of subsection (1), residents are provided with fluids that are adequate in quantity.

Observation conducted on on February 24, 2014, at lunch time on an identified floor dining room, fluids served to the residents at lunch were not adequate in quantity. The residents were served with half glass of juice (60 ml).

An interview with the food service manager confirmed that juice served to the residents should be full glass (125 ml).

A record review of the home's policy #DM-RD-002, titled Hydration Management dated July 2011, revealed that "residents are given an extra 125 ml of water or crystal drink at breakfast, lunch and supper". The home did not comply with this policy. [s. 11. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Observation conducted on on February 24, 2014, revealed that there were a number of chairs with food stains in all dining rooms.

An interview with housekeeping staff revealed that dining room chairs were covered with fabric and stains were not easy to remove by cleaning.

An interview with the AA identified the need to replace or fix dining room chairs as those chairs were covered with fabric, and the stains were not removed by deep cleaning and stain removal. [s. 15. (2) (a)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written description of the responsive behavior program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Review of the home's responsive behaviour program and an interview with the acting DOC confirmed that the program did not include a written description of the program that includes its goals, objectives and relevant policies, procedures and protocols, and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. [s. 30. (1) 1.]

2. The licensee failed to keep a written record relating to each evaluation, that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Review of the home's responsive behavior program and an interview with the acting DOC confirmed that the program had an annual evaluation, but did not include the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made, and the date that those changes were implemented. [s. 30. (1) 4.]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that restraints used for resident #501 and #480 were included in the their plans of care.

Observation made on an identified day, revealed that resident #501 had a seat belt applied, while sitting in his/her wheelchair, and on other identified day, resident #480 was sitting in a tilt wheelchair.

Interview with the nursing staff confirmed that the seat belt used for resident #501 and the tilt wheelchair for resident #480 were not included in the plan of care as they did not considered them as restraints.

Record review revealed that the seat belt and the tilt wheelchair used for above mentioned residents were not included in residents’ plan of care. [s. 31. (1)]

WN #12: 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 failed to ensure that when the resident has fallen, the resident has been assessed and a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Record review revealed that there was no post-fall assessment conducted for resident #478 and #531 after a fall on identified days.

An interview with the acting DOC and registered nursing staff confirmed that post-fall assessments have not been conducted. [s. 49. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

A review of the homes policy NM-I-020 titled Continence Care and Bowel Management Program dated May 2011, revealed that "the interdisciplinary team conduct a bowel and bladder continence assessment utilizing the Bladder and Bowel Continence Assessment tool after any change in condition that may affect bladder or bowel continence".

The MDS assessment from an identified period, for resident #494, indicated that resident has declined in urinary incontinence from frequently to totally incontinent.

Record review revealed that there was no Bladder and Bowel Continence Assessment completed with the decline in resident's urinary incontinence.

Staff interview confirmed that the resident did not have a Bladder and Bowel Continence Assessment completed. [s. 51. (2) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

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

Observation made on an identified day, revealed that accede surface cleaner, peri-wash bottles, and a jar of zinc cream on the unlocked care cart in the open clean linen room on second floor which was accessible to the residents on the floor.

An interview with the staff member confirmed that the door of the clean linen room should be closed and locked as chemicals were inside. [s. 91.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Documentation review of the medication management system meetings and an interview with acting DOC confirmed that quarterly meetings to evaluate the effectiveness of the medication management system did not occur. [s. 115. (1)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident’s condition is assessed or reassessed in developing or revising the resident’s plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident’s condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee failed to ensure that no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident’s condition and needs.

Record review revealed that resident #008 did not have a signed, initialed and dated Medical Directive for an identified medication as required. The MAR did not indicate time, reason or effectiveness of the medication and did not identify that the order was valid for 24 hours.

Interviews with the registered nursing staff and the acting DOC confirmed that the Medical Directive was not individualized to the resident's condition and needs. [s. 117. (b)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 123. Emergency drug supply
Every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure,
(a) that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept;
(b) that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply;
(c) that, at least annually, there is an evaluation done by the persons referred to in clause (a) of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs; and
(d) that any recommended changes resulting from the evaluation are implemented. O. Reg. 79/10, s. 123.

Findings/Faits saillants :

1. The licensee who maintains an emergency drug supply for the home failed to ensure that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept.

Observation conducted on an identified day, of the emergency drug supply box in an identified floor medication room, revealed that two medications contained in the emergency drug supply box were not on the emergency drug supply list. Gravol injectable, a box of 10 ampoules and one extra Nitro spray were found in the emergency supply box. These medications were removed by the registered nursing staff. The emergency inventory stock list was dated March 2011.

Interviews with the acting DOC and registered nursing staff confirmed that the drugs in the emergency drug box did not correspond with the emergency drug list and that the list was outdated. [s. 123. (a)]

WN #18: 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 used exclusively for drugs and drug-related supplies, that is secure and locked; and 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.

On February 27, 2014, the door of the medication room on an identified floor was open, with no registered nursing staff present.

On February 27, 2014, resident #006's prn medication bin contained his/her hearing aid and an identified controlled substance. In the narcotics drawer there was an envelope containing a gold coloured band.

On February 27, 2014, the inspector observed the medication cart in the medication room on an identified floor. The medication cart was not locked and the narcotics drawer was not double locked. The narcotic drawer on the medication cart had only a single locking system and could not be double locked.

On February 27, 2014, the medication cart on another identified floor contained controlled substances which were not double locked. Resident #530, #531, and #007's medication bins contained controlled substances in their normal medication drawer and not double locked.

On March 5, 2014, during medication pass, a registered nursing staff left the medication cart unlocked and unattended in the hallway outside of a residents room, when he/she went into the resident's room to administer medication.

On March 5, 2014, the door of the medication room on the an identified floor was open with no registered nursing staff present.

On March 5, 2014, the medication cart was left unlocked in the nursing station with no registered nursing staff present.

Interviews with the acting DOC and registered nursing staff confirmed that the medication cart should only contain drugs and drug related supplies, the medication cart must be secured and locked, and the narcotics must be double locked. [s. 129. (1) (a)]

2. Medication Administration NM-I-028 revision date March 2013, indicates "medication cart is to be in the registered staff's line of vision at all times and must be locked when nurse cannot see the cart. Narcotics and controlled drugs are to be counted by two registered staff (one come on shift and one going off shift) and recorded on appropriate form".

Observation conducted on February 28, March 4 and 5, 2014, revealed that the medication cart was left unlocked and no registered nursing staff present. Two identified controlled substances for resident #531, #530 and #007 were found in their individualized medication bins. These controlled substances were not counted and not double locked.

An interview with the acting DOC confirmed that the home did not double lock or count these controlled substances. [s. 129. (1) (b)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Record review revealed that on an identified day, the physician ordered for resident #453, an identified medication once daily for one month that should have been discontinued on an identified day. The resident continued to receive the medication until this error was identified.

Interviews with registered nursing staff and acting DOC confirmed that the medication should have been discontinued on an identified day. [s. 131. (2)]

2. The home policy NM-I-024 titled Medication Review dated September 2013, and West End Pharmacy policy titled Three-Month Physician Medication Review, amended March 2011 revealed that any medication orders previous to the three month physician's medication review are to be discontinued and that they are to be updated by reviewing all of the physicians orders since the previous review was signed.

On an identified day, the physician's order for resident #011 was changed. The three month drug review completed on an identified day does not reflect the change in order as required by the home's policy.

Interviews with the acting DOC and registered nursing staff confirmed that the registered nursing staff did not update the three months drug review when the new order was written. Once signed by the physician and the order was not discontinued as required by the policy.[s. 131. (2)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)

Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee failed to ensure that a drug record is established, maintained and kept in the home for at least two years, in which the following information is recorded in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered
2. The signature of the person placing the order
3. The name, strength and quantity of the drug
4. The name of the place from which the drug is ordered
5. The name of the resident for whom the drug is prescribed, where applicable
6. The prescription number, where applicable.

A review of the drug record book revealed that the following drugs were not recorded into the drug record book:
- Trazadone 50 mg
- Adasept skin cleaneser 0.5 percent
- Lorazepam 1 mg, and
- Resperidone 0.25 mg.

Interviews with the acting DOC and registered nursing staff confirmed that they did not record the above mentioned identified medications new orders into the drug record book. [s. 133.]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and O. Reg. 79/10, s. 136 (3).

s. 136. (4) Where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy must provide that the team composed of the persons referred to in clause (3) (a) shall document the following in the drug record:
1. The date of removal of the drug from the drug storage area. O. Reg. 79/10, s. 136 (4).
2. The name of the resident for whom the drug was prescribed, where applicable. O. Reg. 79/10, s. 136 (4).
3. The prescription number of the drug, where applicable. O. Reg. 79/10, s. 136 (4).
4. The drug's name, strength and quantity. O. Reg. 79/10, s. 136 (4).
5. The reason for destruction. O. Reg. 79/10, s. 136 (4).
6. The date when the drug was destroyed. O. Reg. 79/10, s. 136 (4).
7. The names of the members of the team who destroyed the drug. O. Reg. 79/10, s. 136 (4).
8. The manner of destruction of the drug. O. Reg. 79/10, s. 136 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's drug destruction and disposal policy provides that any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any

controlled substance that is available for administration to a resident, until the destruction and disposal occurs as required by s 136. (2) 2.

The homes policy Drug Destruction and Disposal NM-I-101 revision date December 2012, indicates that "all drugs for destruction and disposals are to be placed in the designated area, blue plastic container in the medication room on the 3rd floor". This policy is not in compliance with the Act.

Observation conducted on an identified day, revealed that controlled substances were placed in a single locked cupboard in the DOC's office.

Interviews with the assistant DOC and registered nursing staff confirmed the controlled substances were not placed in a double-locked storage area. [s. 136. (2) 2.]

2. The licensee failed to ensure that, as part of the medication management system, drugs are destroyed by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care and a physician or a pharmacist.

The homes policy Drug Destruction and Disposal NM-I-101 revision date December 2012, stated "a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable (crushing)".

Record review of "Individual Resident's Narcotic/Controlled Substances Record" for resident #478 and resident #004 indicated that the controlled substances were crushed and returned to the pharmacy for proper disposal.

An interview with the assistant DOC confirmed that the controlled substances were not crushed and destroyed with the pharmacist and instead the pharmacist took them back to the pharmacy to be destroyed. [s. 136. (3) (a)]

3. The licensee failed to ensure where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy provides that the team composed of the persons referred to in clause (3) (a) shall document the following in the drug record: the reason for destruction.

Record review of resident #478 and resident #004 revealed that their Individual Residents' Narcotic or Controlled Substance Record did not indicate the reason for

destruction.

An interview with the acting DOC confirmed that there was no reason documented for destruction identified on his/her Narcotic or Controlled Substance Record. [s. 136. (4)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Record review revealed that resident #012 was admitted on an identified day, was not screened for tuberculosis (TB). There was no evidence of chest x-ray or TB skin test performed 90 days prior to admission or within 14 days of admission.

Interviews with registered nursing staff and acting DOC confirmed that there was no record of chest x-ray or TB skin test performed on the resident 90 days prior to admission or within 14 days of admission. [s. 229. (10) 1.]

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

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L’INSPECTION**	**INSPECTOR ID #/ NO DE L’INSPECTEUR**
O.Reg 79/10 s. 16.	CO #901	2014_237500_0005	500
O.Reg 79/10 s. 16.	CO #902	2014_237500_0005	500

Issued on this 29th day of May, 2014

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

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NITAL SHETH (500), TILDA HUI (512), VALERIE PIMENTEL (557)
Inspection No. / No de l'inspection :	2014_237500_0005
Log No. / Registre no:	T-45-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 24, May 13, 2014
Licensee / Titulaire de permis :	UKRAINIAN HOME FOR THE AGED 767 Royal York Rd., TORONTO, ON, M8Y-2T3
LTC Home / Foyer de SLD :	IVAN FRANKO HOME 767 Royal York Road, TORONTO, ON, M8Y-2T3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARIA KIEBALO

To UKRAINIAN HOME FOR THE AGED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 901 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Order / Ordre :

The licensee of a long-term care home shall ensure that the windows in four identified rooms on an identified floor in the home that open to the outdoors and is accessible to residents do not open more than 15 centimetres (cm).

Grounds / Motifs :

1. The licensee failed to ensure that the windows in four identified rooms on an identified floor in the home that open to the outdoors and is accessible to residents do not open more than 15 centimetres (cm).

Observation conducted on February 24, 2014 at 11:30 hours, revealed that the four identified resident's rooms on an identified floor have windows that open 50 cm. The locking mechanisms on the windows to stop windows from opening more than 15 cm, were observed to be broken.

Interview with the assistant administrator confirmed that the window in an identified room was known to be broken and replacement window has been ordered by the home. The assistant administrator stated he/she was not aware of the locking mechanisms being broken in the other three identified rooms. (500)

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

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

Order # / Ordre no : 902

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Order / Ordre :

The licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened greater than 15 centimetres (cm).

The licensee shall prepare, submit and implement a plan to ensure that every window in the home that is accessible to residents does not open greater than 15 cm. The plan shall outline the home's immediate, short-term and long-term actions to identify, monitor and implement corrective actions to address windows that open greater than 15 cm.

This plan is to be submitted to the inspector.

Grounds / Motifs :

1. The licensee failed to ensure that the windows in four identified rooms on an identified floor in the home that open to the outdoors and is accessible to residents do not open more than 15 centimetres (cm).

Observation conducted on February 24, 2014 at 11:30 hours, revealed that the four identified resident's rooms on an identified floor have windows that open 50 cm. The locking mechanisms on the windows to stop windows from opening more than 15 cm, were observed to be broken.

Interview with the assistant administrator confirmed that the window in an identified room was known to be broken and replacement window has been ordered by the home. The assistant administrator stated he/she was not aware of the locking mechanisms being broken in the other three identified rooms. (500)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 03, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 24th day of February, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Nital Sheth

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