Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 26, 2014	2014_321501_0016	T-000140-14	Resident Quality Inspection

Licensee/Titulaire de permis

ROYAL CANADIAN LEGION DISTRICT 'D' CARE CENTRES
59 Lawson Rd TORONTO ON M1C 2J1

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

TONY STACEY CENTRE FOR VETERANS' CARE
59 Lawson Road TORONTO ON M1C 2J1

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

SUSAN SEMEREDY (501), GWEN COLES (555), PATRICIA BELL (571)

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): September 15, 16, 17, 18, 19, 22, 23, 24, 25, and 26, 2014.

This inspection was conducted concurrently with three complaint inspections (T-854-13, T-5810-14, and T-1131-14) and one critical incident (T-337-14).

During the course of the inspection, the inspector(s) spoke with the acting Administrator, Director of Care (DOC), program manager, acting environmental manager, nurse managers, food services manager (FSM), registered dietitian (RD), physiotherapy assistant, registered nursing staff, personal support workers (PSWs), cook, maintenance staff, housekeeping staff, residents and substitute decision makers (SDMs).

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
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
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Snack Observation

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

28 WN(s)
16 VPC(s)
2 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 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 has failed to 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.
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.
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.

Throughout this inspection, inspectors found a lack of program descriptions that included goals, objectives, policies and procedures which resulted in disorganized actions on the part of staff members and poor outcomes for residents.

Specifically the programs identified included (but may not be limited to):
-Nursing and personal support services
-Dietary services and hydration
-Accommodation services
-Falls prevention and management program
-Skin and wound care program
-Continence care and bowel program
-Pain management program.

Record review revealed that many forms were available to monitor and assess the residents but their use was inconsistent as there was little direction of when or how to use them. As well, referrals were not always being made to specialists when required as evidenced by a lack of referral to the dietitian for poor intake and wound care. Interview with the acting Administrator and DOC confirmed that if structured programs were in place with specific policies and procedures, there would be better guidance for staff and improved outcome for residents.

During this inspection the inspectors found no evidence that the above mentioned programs were being evaluated and updated. Interview with the DOC confirmed that no annual evaluations of programs occur. [s. 30. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1)

performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff receive training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities.

Review of the document titled "Orientation - Facility" dated January 1, 2011, found no reference to training on mandatory reporting under section 24 of the Act . Interviews with the DOC and acting Administrator revealed they are responsible for staff training and follow the "Orientation- Facility" document in order to provide training. The DOC and acting Administrator confirmed the home does not provide staff with training on mandatory reporting under section 24 of the Act. [s. 76. (2) 4.]

2. The licensee has failed to ensure that all staff receive retraining annually related to: Resident's Bill of Rights; zero tolerance of abuse and neglect; mandatory reporting under section 24; and whistle-blowing protection.

Review of staff training records provided for 2013 found 52 per cent of staff members did not receive retraining related to the Residents' Bill of Rights; there was no evidence at all of retraining related to zero tolerance of abuse and neglect, mandatory reporting and whistle-blowing protection.

Interview with the acting Administrator confirmed the above numbers and reported there are no other training records available related to zero tolerance of abuse, mandatory reporting or whistle-blowing protection for 2013. [s. 76. (4)]

3. The licensee has failed to ensure that all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training relating to mental health issues, including caring for persons with dementia.

Record review revealed there are no training records related to mental health issues, including caring for persons with dementia.

Interview with the acting Administrator indicated that he/she was not aware that there had been education in these areas and that records for 2013 staff education for mental health issues and dementia could not be found. [s. 76. (7) 2.]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training relating to mental health issues, including caring for persons with dementia, 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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Record review indicated resident #3 had sustained a fractured pelvis from a fall on a specified date.

The plan of care indicated that resident #3 may have a hot pack for 15 minutes to the pelvic area if the resident does not have swelling; if the resident has swelling then an ice pack may be applied for 15 minutes. In addition, the resident was to receive treatment with a Transcutaneous Electric Nerve Stimulation (TENS) machine for 20 minutes, three times a week. These interventions were initiated on a specified date.

Interview with a physiotherapy assistant indicated that resident #3 no longer receives hot or ice packs or treatment with the TENS machine. [s. 6. (1) (c)]

2. Record review revealed that resident #13 had three falls during a specified time period. Family and staff interviews revealed that resident #13 gets impatient and will not call or wait to be assisted with toileting which has resulted in two of the last three falls. Review of the resident's plan of care revealed that one person is to constantly supervise with toileting and also that two person total assistance is required for the entire process of toileting. Interview with an identified nurse manager confirmed that this plan of care does not give clear directions to staff. [s. 6. (1) (c)]

3. Record review revealed that resident #18 was hospitalized for pneumonia during a specified time period. Before entering the hospital he/she was on a g-tube feed with some intake of a pureed thickened fluid diet. Upon return from hospital, the resident was prescribed nothing by mouth (NPO) and the enteral feed was reassessed by the RD. Record review revealed that the plan of care was not updated and still had the resident consuming a pureed thickened fluid diet. Interview with the DOC confirmed that this plan of care needed to be updated in order to give clear direction to staff. [s. 6. (1) (c)]

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

On a specified date, the inspector observed that resident #5 was served regular textured quiche and mixed vegetables. Record review revealed that the resident is to receive a minced textured diet. Interview with the cook revealed that this resident should have been served minced quiche and minced vegetables and the dietary aides and PSWs were responsible for ensuring this. Interview with the FSM confirmed this resident was not provided care as specified in the plan of care. [s. 6. (7)]

5. Record review revealed that resident #13 had three falls during a specified time period, and the plan of care for toileting of this resident indicated he/she needed to be constantly supervised when toileting for safety. Family and staff interview revealed that for at least one of those falls the resident was assisted onto the toilet, and although staff remained in the room, they were unable to assist the resident as they were wearing personal protective equipment for the resident's roommate. Interview with the nurse manager confirmed that although the staff stated they had applied brakes to the resident's wheelchair, they did not remain in the bathroom with the resident and assist him/her off the toilet. [s. 6. (7)]

6. The licensee has failed to ensure that when a resident is reassessed and the plan of care is revised because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care.

Record review revealed that resident #13 had three falls during a specified time period. Family and staff interview revealed that resident #13 gets impatient and will not call or wait to be assisted with toileting and getting into bed and this has resulted in the recent falls. Record review revealed that these three falls have been documented on the plan of care but no changes to interventions have been made. Interview with an identified nurse manager confirmed that without a new approach to resident #13's plan of care, there could be further falls. [s. 6. (11) (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 the plan of care sets out clear directions to staff and others who provide direct care to the resident, the care set out in the plan of care is provided to the resident as specified in the plan and that when a resident is reassessed and the plan of care is revised because care set out in the plan has not been effective, have different approaches been considered in the revision of the plan of care, to be implemented voluntarily.

WN #4: 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 has failed to ensure that the home is maintained in a good state of repair.

During the period from September 15 to 17, 2014 the following was observed:
Room #214 - the flooring in bedroom and bathroom was stained and raised at the seams, chipped paint was noted on the walls; and cracks in the ceiling;
Room #119 - the walls and doors were scuffed, the tile at the entrance way had a large chip out of it.

Additional resident rooms were observed to have chipped paint, unfinished patching, discoloured flooring and ceiling cracks.

Common areas located throughout the building were observed to have
-chipped paint on the walls, window ledges and door frames;
-one toilet seat lid was half off and the handle was loose in the shower room on the first floor of the pink wing;
- one hole in the ceiling, patches on the ceilings, and holes in walls stuffed with Styrofoam or unfilled;
- baseboards separated from walls in the shower room on the second floor of the green wing;
- rusted cover plates in the shower room of the second floor of the pink wing;
- discoloured grouting in the tiles in all shower rooms;
- missing covers or broken covers on the hallway lights, and light bulbs burnt out in hallway;
- flooring in front of nursing stations was cracked and soiled; and
- rust around the tub drain of the tub room on the second floor of the pink wing.

Review of the home's policy titled Maintenance indicates:
- Policy - to ensure building is kept in a state of good repair.
- Purpose - to maintain a safe and comfortable environment for residents and staff.
- Procedure - First thing Monday morning or the first day of the work week should Monday be a holiday, each designated area will be checked for repairs and maintenance. Person assigned to that area will also check the maintenance log books on their floors.

Review of the maintenance log books for both the first and second floors from August 1 to September 18, 2014, found no records of rooms or common areas requiring plastering and painting. Review of maintenance weekly/biweekly duties found no reference to plastering, painting, lighting repairs, stripping floors or floor repairs.

Interview with the acting Administrator (regular position being environmental manager) revealed that once a month he/she does an audit of resident rooms and notes on maintenance work order forms or writes maintenance needed in log books. He/she also indicated that any staff may note maintenance needed in the log books which triggers the maintenance staff to complete work. The acting Administrator reports that documentation in May 2014 indicated that several resident rooms throughout facility required painting and plastering, and remain outstanding. He/she also reported plastering and painting should be completed within one day, and is aware that many areas are plastered but not painted. He/she is aware that, as per policy, each area should be checked for repairs and maintenance weekly and repairs should be completed in a timely manner.

A tour of home was made with the acting Administrator and the inspector on September 22, 2014, and areas of disrepair were then noted by the acting Administrator in the maintenance log book. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is kept clean and sanitary and maintained in a good state of repair, to be implemented voluntarily.

WN #5: 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 has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres.

It was observed on September 15, 2014, that rooms #119, #210 and a shower room on the second floor had windows that opened greater than 15 centimetres. Inspectors reported this issue on September 15, 2014, to the acting Administrator for followup. Inspectors observed on September 16 and 23, 2014 that these windows had been secured to not open greater than 15 centimetres. [s. 16.]

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 window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone.

Interview with resident #10's SDM revealed that resident #10 had been assaulted by another resident.

Record review revealed that on a specified date, resident #29 pushed resident #10 who fell and sustained a laceration and lump on the head which required transfer to the hospital for assessment and treatment. Review of records indicated resident #29 was seen by a social worker regarding behaviour on a specified date, and placed on increased staff monitoring of every 15 minute safety checks.

Interviews with registered staff including the DOC revealed that resident #29 was placed on every 15 minute monitoring and interventions were initiated to keep resident #10 and resident #29 apart including re-direction and relocation of resident #29's bedroom to another floor.

Record review revealed that on a specified date, resident #29 slapped resident #10 but did not require transfer to hospital. According to the resident incident report, resident #29's bedroom had been moved to another floor. Record review indicated resident #29's file was reviewed by the Behavioural Support Team on a specified date, which included a medication review with recommendations forwarded to the physician. Resident #29 continued on every 15 minute safety checks.

Record review revealed that on a specified date, resident #29's file was reviewed by a psychiatric nurse which included a medication review with no new interventions noted.

Record review revealed that on a specified date, resident #29 grabbed resident #10 and no injury was reported. Resident #29 was spoken to by staff and continued to receive safety monitoring. On a specified date, resident #29's medications were changed by the Geriatric Mental Health Outpatient Team due to incidents involving physical aggression towards resident #10 as well as others.

Record review revealed that on a specified date, resident #29 hit resident #10 and no injury was reported. On a specified date, resident #29 was transferred for psychiatric assessment to hospital and returned from hospital on a specified date. On another specified date, resident #29 was again transferred for psychiatric assessment to hospital. Resident #29 did not return to the home. [s. 19. (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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

Record review and family interview revealed that on a specified date, resident #29 pushed resident #10 after a verbal altercation. Resident #10 sustained a laceration and lump to the head which required transfer to the hospital for assessment and treatment.

Review of the home's policy titled Abuse and Negligence and dated January 1, 2011, indicates:

-Definition of Abuse: Abuse of a resident means any action or inaction or power and/or betrayal of trust or respect by a person against a resident, that the person knew or ought to have known, would cause (or could reasonably be expected to cause) harm to resident's safety or well-being.

-Definition of Assault: ...Intentionally applying force to the resident, directly or indirectly, without the resident's consent.

-Police notification: The Administrator or Director of Care will ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incidence of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

There is no evidence that the Administrator or Director of Care notified the police of the incident of physical abuse involving resident #10.

-Notify the Ministry of Health and Long Term Care according to legislation.

There is no evidence that the Ministry of Health and Long Term Care was notified according to the legislation of the incident of physical abuse involving resident #10.

-Annually an evaluation is made to determine the effectiveness of the policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

There is no evidence of an annual evaluation of the policy related to zero tolerance of abuse and neglect.

-A written record of the annual evaluation including changes to the policy and procedure along with the implementation of the change is completed following the review.

There is no evidence of an annual evaluation of the policy related to zero tolerance of abuse and neglect.

Interview with the DOC defined physical abuse as punching/pushing by anyone, and that the above incident, qualifies as abuse. The DOC indicated that all reporting to the Director is completed by the Administrator and he/she assists but has not completed a submission independently. The DOC stated that reporting to the Ministry of Health and Long Term Care is done if a written complaint of abuse is received, and was not aware that it was done with regards to alleged, suspected or witnessed abuse.

Interview with the acting Administrator defined physical abuse as any physical force that causes physical harm. The acting Administrator revealed that there was no submission of a critical incident for the incident involving resident #10, and there were no additional investigation notes available. The acting Administrator confirmed that the incident with resident #10 would constitute physical abuse. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

On September 15, 2014, the inspector observed in the second floor tub room a "Breeze" bath lift chair without any seatbelt in place; metal loops were noted on the back of the empty chair where a seat belt would be located.

The acting environmental manager was contacted for a request of a manufacturer's manual and provided a copy of a German information sheet for a similar product called a "Hektor" which included a picture indicating a seat belt in place. The home was unable to provide a English manual related to the "Breeze" model.

Following an interview with the acting Administrator on September 17, 2014, regarding the lack of a seatbelt for the "Breeze" lift, the lift was removed from service.

Interview on September 19, 2014, with the acting environment manager revealed he/she found information that indicated the "Breeze" model is a North American version of the "Hektor" German lift and provided a "Hektor" user manual dated 2007 as a manufacturer's manual for "Breeze" model of bath lift chair.

Review of user manual indicated:
Components: safety belt;
Note: it is recommended that the patient holds onto the surrounding rail and the safety strap is fitted during patient transport;
...the lifter is always operated by trained personnel who follow the instructions given in the Operating Manual.
Note: The safety rules and instructions in this operating manual must be observed in order to ensure the safe and proper use of the equipment.

The licensee failed to have a manufacturer's manual in place related to the "Breeze" bath lift chair and therefore staff were unable to follow the manufacturer's recommendations related to the safe operation of the equipment. [s. 23.]

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 staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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 had reasonable grounds to suspect that abuse of a resident by anyone has occurred should immediately report the suspicion and the information upon which it was based to the Director.

Record review and family interview revealed that on a specified date, resident #29 pushed resident #10 after a verbal altercation. This resulted in resident #10 falling to the floor and sustaining a laceration and lump to the head which required transfer to the hospital for assessment and treatment.

Record review revealed that this incident was not reported to the Director. Interviews with the nurse manager, DOC and acting Administrator revealed that they were aware that, if a resident pushed another resident and caused harm, this would constitute physical abuse.

The nurse manager, DOC and acting Administrator confirmed that the incident involving resident #10 was a form of physical abuse and was not reported to the Director. [s. 24. (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 a person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred should immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #3 included mood and behaviour patterns, identified responsive behaviours, potential triggers and variations in resident functioning at different times of the day.

Record review revealed that resident #3 during a certain time period, had at least 58 episodes of responsive behaviours including exit seeking, screaming, hitting, kicking, crying and resisting care.

After reviewing the plan of care, no mention of the responsive behaviours, triggers or interventions could be found.

Interviews with an identified registered staff member indicated that he/she was not sure of resident #3's responsive behaviour triggers. Interview with the nurse manager confirmed that resident #3 was not referred to the Behaviour Support Ontario team and responsive behaviours was not included in the plan of care. [s. 26. (3) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care includes mood and behaviour patterns, identified responsive behaviours, potential triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #11: 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 has failed to ensure that a resident who is incontinent receives an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the circumstances of the resident require.

Review of the home's policy titled Continence Care dated August 17, 2014, indicates each resident's bowel and bladder functioning, including individual routines and the residents' level of continence, shall be reassessed when there is any change in the resident's health status that affects continence.

On a specified date, the inspector observed resident #10 having issues with toileting and requesting staff assistance. Interview with family members revealed the resident has been increasingly incontinent. Staff interviews revealed that the resident was initially continent but, recently has had a deterioration in cognitive and physical status and now requires increased assistance with toileting and presents increased incontinence. It was also noted that periodically the resident is able to toilet self with limited assistance from staff. Staff also reported continence assessments are done on admission and with any significant changes in status.

Record review revealed that resident #10 had a continence assessment on admission indicating the resident was continent, but there were no subsequent assessments. Record review during a specific time frame, indicated resident had not been continent since a specified date. [s. 51. (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 a resident who is incontinent receives an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the circumstances of the resident require, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #9's pain was not relieved, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Record review revealed that resident #9 complained of severe lower back pain during a specified time frame.

A review of the physician orders during a specified time frame, indicated that an order for an analgesic was increased four times.

Record review revealed there was no assessment for pain using a clinically appropriate assessment instrument for resident #9. [s. 52. (2)]

2. Record review indicated resident #3 had a fall and sustained a fracture of the pelvis.

Record review indicated that on a specified date, at a specified time, the resident fell

while being escorted by staff to the bathroom and the resident was sent to the hospital due to hip pain and decreased movement. No pain assessment was found in the resident's record. On a specified date, at a specified time, resident #3 was given an analgesic for facial grimacing. There is no evidence of a clinically appropriate assessment instrument to assess the resident's pain.

Record review revealed that during a specified time period, there were 27 entries regarding resident #3 screaming or yelling and nine entries describing the resident as weepy. No evidence of a pain assessment was found. [s. 52. (2)]

3. Record review for resident #8 indicated that on:
-On a specified date, resident complained of abdominal pain and an ice pack was applied at a specified time. On another specified date at a specified time the resident indicated that a little pain remained.
-On another specified date at a specified time, resident advised staff that the pain had been present for several days and was not relieved after taking analgesic.
-On another specified date at a specified time, an analgesic was given to the resident for complaint of groin pain.
-On another specified date at a specified time, an analgesic was given for complaint of abdominal pain.

No evidence of a pain assessment using a clinically appropriate assessment instrument could be found.

Interview with an identified nurse manager confirmed that staff do not use an assessment instrument for pain. [s. 52. (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's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following are developed to meet the needs of residents with responsive behaviours:

1. Written approaches to care including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required.

Interview with the DOC indicated that the home has not developed the required interventions to meet the needs of residents with responsive behaviours.

Interview with an identified nurse manager revealed that the Behaviour Support Ontario (BSO) team within the home does not have a written procedure that they follow. [s. 53. (1) 1.]

2. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified where possible.

Record review revealed that resident #3 during a specified time period demonstrated responsive behaviours on at least 58 occasions which included behaviours such as screaming, hitting, kicking, crying and resisting care.

Interview with an identified registered staff member identified one trigger for resident #3's responsive behaviours while in a separate interview, an identified PSW identified a different trigger. Record review confirmed these or any other triggers were not documented. [s. 53. (4) (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 following are developed to meet the needs of residents with responsive behaviours:

1. Written approaches to care including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required and that, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified where possible, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a weight monitoring system to measure and record each resident's weight monthly.

Record review revealed that resident #5 was admitted on a certain date, and noted to have a 5.9 kilogram weight loss, representing an 11.6 per cent weight change over two months. It was also revealed that a weight for this resident was not recorded for a specified month. A referral was not made to the RD until two months later when a nutritional supplement was added.

Review of the home's policy titled Weight Changes dated January 1, 2011, states that every resident is to be weighed monthly. Interview with the FSM and RD confirmed that not all weights are taken and recorded monthly as per the home's policy. [s. 68. (2) (e) (i)]

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 weight monitoring system to measure and record each resident's weight monthly, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse that the licensee suspects may constitute a criminal offense.

Record review revealed that on a specified date, resident #29 pushed resident #10 to the floor after a verbal altercation. Resident #10 sustained a laceration and lump to the head which resulted in transfer to the hospital for assessment and treatment.

Interview with resident #10's SDM indicated that when he/she was informed of the incident he/she contacted the police. Interview with an identified nurse manager confirmed the SDM had called the police following this incident. This nurse manager also revealed he/she informed the police that the incident would be handled internally. Interview with the acting Administrator confirmed that a resident pushing another resident constitutes physical abuse and as a result the home should have notified the police. [s. 98.]

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 appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse that the licensee suspects may constitute a criminal offense, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it.

Record review revealed that on a specified date, resident #10 was pushed to the floor by resident #29 following a verbal altercation. Resident #10 sustained a laceration and lump to the head resulting in transfer to hospital for assessment and treatment.

Interviews with registered staff, a nurse manager, the DOC and the acting Administrator revealed that they were aware that a resident pushing another resident which results in physical harm constitutes physical abuse.

Interview with the acting Administrator confirmed that there is no evidence related to an analysis of the incident of physical abuse involving Resident #10. [s. 99. (a)]

2. The licensee has failed to ensure that at least once in every calendar year an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents.

Interviews with the DOC and acting Administrator confirmed there is no evaluation of the home's policy to promote zero tolerance of abuse and neglect of residents [s. 99. (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 an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it and that at least once in every calendar year an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all direct care staff are provided training in falls prevention and management.

Record review revealed that approximately 71 per cent of direct care staff did not receive training in falls prevention and management in 2013. Interview with the acting Administrator confirmed not all direct care staff were trained in falls prevention and management in 2013. [s. 221. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all direct care staff are provided training in falls prevention and management, to be implemented voluntarily.

WN #18: 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the residents receiving foot care treatment where provided treatment in private.

On September 17, 2014, the inspector observed the foot care clinic being provided in a resident lounge on the first floor. There were no doors to provide privacy and the area is located centrally on the unit with two entrance ways. Three residents were observed receiving foot care at the same time that other residents, staff and visitors passed through or by the lounge.

Interview with the agency staff performing the foot clinic revealed there were no privacy curtains available. Interview with the acting Administrator confirmed this clinic should be conducted in a more private area. [s. 3. (1) 8.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 25. Initial plan of care

Specifically failed to comply with the following:

s. 25. (1) Every licensee of a long-term care home shall ensure that,
(a) the assessments necessary to develop an initial plan of care under subsection 6 (6) of the Act are completed within 14 days of the resident's admission; and O. Reg. 79/10, s. 25 (1).
(b) the initial plan of care is developed within 21 days of the admission. O. Reg. 79/10, s. 25 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the initial plan of care is developed within 21 days of admission.

Record review revealed that resident #22 was admitted to the home on a specified date, and the plan of care was incomplete as of a specified date, which was greater that 21 days. Review of health records found a plan of care dated on a specified date which included only details related to transferring, mobility and nutritional risk.

Interview with an identified nurse manager confirmed that resident #22's plan of care was not completed within 21 days of admission. [s. 25. (1)]

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee convenes semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council.

Interview with the acting Administrator revealed that the home does not have a Family Council and convenes only annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council. Record review revealed that a monthly newsletter informs the families that the home is looking to start a Family Council group, however, there is no record of meetings with families to advise them of their right to establish a Family Council on a semi-annual basis. [s. 59. (7) (b)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning
Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents are offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

Interviews with residents #24 and #25 revealed that between-meal beverages are not always offered.

Record review revealed that nourishments are to be served daily at 10:30 a.m., 2:30 p.m. and 7:30 p.m.

On September 25, 2014, the inspector observed the nourishment carts to be placed at the nursing station on the second floor from 10:20 a.m. until 11:12 a.m. During this time, some residents helped themselves to beverages but staff were not observed taking the cart down the hallway to offer other residents beverages. Interview with resident #23 in his/her room on the second floor confirmed that he/she was not offered a beverage that morning.

Interview with registered staff confirmed that due to an in-service, the PSWs did not have time to ensure all residents were offered a beverage at 10:30 a.m. on September 25, 2014. [s. 71. (3) (b)]

2. The licensee has failed to ensure that menu items are offered and available at each meal and snack.

On a specified date, the inspector observed resident #5 who has a history of chewing and swallowing problems, to receive regular textured quiche and regular mixed vegetables at lunch.

Record review revealed resident #5 was to receive minced textured items and the menu for lunch was quiche with mixed vegetable. Interview with the cook revealed that he/she had not minced the quiche as planned for on the therapeutic spreadsheet and although minced mixed vegetables were available, they were not offered to this resident.

Interview with the FSM confirmed that minced quiche should have been available and minced mixed vegetables should have been offered to resident #5. [s. 71. (4)]

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the satisfaction survey are documented and made available to the Residents' Council.

Interview with the Residents' Council president revealed that she was not aware of the results of the satisfaction survey. Interview with the acting Administrator confirmed there is no evidence of a review of the 2013 satisfaction survey results with Residents' Council, and that the current 2014 satisfaction survey results have yet to be compiled. [s. 85. (4) (a)]

WN #23: 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is notified immediately in the event of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

Record review revealed that on December 31, 2013, the licensee notified the local Public Health Unit of an enteric outbreak affecting several residents. The critical incident was not reported to the Director until January 2, 2014.

Interview with the DOC confirmed that the outbreak was declared, Public Health was notified and surveillance was initiated on December 31, 2014. The DOC revealed that the Administrator who was on vacation at that time was the only one who knows how to submit electronic critical incidents. Upon return from the vacation on January 2, 2014, the Administrator submitted the critical incident. The DOC confirmed that the Director was not notified immediately of this outbreak. [s. 107. (1)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, and administration of all drugs used in the home.

The licensee has failed to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, and administration of all drugs used in the home.

A review of the medication policy provided by the DOC contains the following categories: drug disposal, emergency drug box, vacation supply form, a self medication policy and a policy on changes in drug orders. Policies regarding the accurate acquisition, dispensing, receipt, storage, and administration of all drugs used in the home could not be found.

Interview with the DOC confirmed that the policy provided was the entire policy. [s. 114. (2)]

2. The licensee has failed to ensure that the written policies and protocols are reviewed and approved by the Director of Care and the pharmacy service provider and, where appropriate, the Medical Director.

Interviews with the DOC and the acting Administrator indicated that none of the home's policies or programs are reviewed annually including those for medication management. [s. 114. (3) (b)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 120. Responsibilities of pharmacy service provider

Every licensee of a long-term care home shall ensure that the pharmacy service provider participates in the following activities:

1. For each resident of the home, the development of medication assessments, medication administration records and records for medication reassessment, and the maintenance of medication profiles.

2. Evaluation of therapeutic outcomes of drugs for residents.

3. Risk management and quality improvement activities, including review of medication incidents, adverse drug reactions and drug utilization.

4. Developing audit protocols for the pharmacy service provider to evaluate the medication management system.

5. Educational support to the staff of the home in relation to drugs.

6. Drug destruction and disposal under clause 136 (3) (a) if required by the licensee's policy. O. Reg. 79/10, s. 120.

Findings/Faits saillants :

1. The licensee has failed to ensure that the pharmacy service provider participates in developing audit protocols for the pharmacy service provider to evaluate the medication management system.

Interviews with the nurse manager and the DOC confirmed that the pharmacy service provider does not participate in developing audit protocols for the pharmacy service provider to evaluate the medication management system. [s. 120. 4.]

WN #26: 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. On September 15, 2014, the inspector observed an unattended and unlocked treatment
cart at the first floor nursing station that is accessible to residents, visitors and staff. The treatment cart contained prescription medications such as Fucidin cream, hydrocortisone acetate and Voltaren Emulgel. Interview with the DOC confirmed that the treatment cart should have been locked. [s. 129. (1) (a) (ii)]

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that there is monitoring and documentation of resident #9's response and the effectiveness of a certain medication.

Record review revealed resident #9 has had lower back pain which at times has been described as severe.

A review of the physician orders indicated that during a specified time period, the dose for the administration of the medication was increased three times.

Interview with an identified nurse manager indicated that staff do not use an assessment instrument but rather monitor and document effectiveness of analgesic on nurses medication/treatment record, or in the progress notes.

Record review found no evidence of monitoring or documentation of resident #9's response and the effectiveness of the medication for the resident's complaint of pain. [s. 134. (a)]

WN #28: 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. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

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

s. 229. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).

Findings/Faits saillants :

1. The licensee has failed to ensure that the infection prevention and control program is evaluated and updated at least annually in accordance with evidence-based practices.

Interview with the DOC revealed there is no written annual evaluation of the infection prevention and control program. [s. 229. (2) (d)]

2. The licensee has failed to ensure that residents are offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funding immunization schedules.

Record review revealed that resident #10 was not offered immunization against tetanus and diphtheria. Interview with the DOC confirmed that there is no evidence that resident #10 was offered tetanus and diphtheria immunization. [s. 229. (10) 3.]

3. The licensee has failed to ensure that staff are screened for tuberculosis (TB) in accordance with evidence-based practices.

Record review revealed that one staff member hired on a specified date, did not have any TB screening. Interview with the DOC confirmed this staff member did not provide evidence of TB screening at the time of hire. The DOC contacted the staff member who was unable to provide information related to TB screening. [s. 229. (10) 4.]

4. The licensee has failed to ensure that all pets visiting the home have up-to-date immunizations.

On September 15, 2014, the inspector observed a visitor bringing a small dog into the home. Review of the home's policy titled Pet-Friendly Policy dated August 2011, indicates pets are welcome with the following restrictions: staff ask families if their pets immunizations is up-to-date.

Interview with the program manager revealed that some families do bring dogs into the home, however the home has no evidence of asking families/visitors if their pets have up to date immunizations. The program manager confirmed that residents could be at risk if pets visiting the home did not have up to date immunizations. [s. 229. (12)]

Issued on this 10th day of December, 2014

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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) :	SUSAN SEMEREDY (501), GWEN COLES (555), PATRICIA BELL (571)
Inspection No. / No de l'inspection :	2014_321501_0016
Log No. / Registre no:	T-000140-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 26, 2014
Licensee / Titulaire de permis :	ROYAL CANADIAN LEGION DISTRICT 'D' CARE CENTRES 59 Lawson Rd, TORONTO, ON, M1C-2J1
LTC Home / Foyer de SLD :	TONY STACEY CENTRE FOR VETERANS' CARE 59 Lawson Road, TORONTO, ON, M1C-2J1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CATHERINE HILGE

To ROYAL CANADIAN LEGION DISTRICT 'D' CARE CENTRES, 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) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, 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.
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.
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.
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).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O.Reg.79/10 s.30(1) to 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 O.Reg.79/10.

1. There must be 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 outcome, including protocols for the referral of residents to specialized resources.
2. 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.
3. The licensee shall 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.

The plan is to be emailed to susan.semeredy@ontario.ca by December 10, 2014.

Grounds / Motifs :

1. The licensee has failed to 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:
A. 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.
B. 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.
C. 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.

Throughout this inspection, inspectors found a lack of program descriptions that

included goals, objectives, policies and procedures which resulted in disorganized actions on the part of staff members and poor outcomes for residents.

Specifically the programs identified included (but may not be limited to):
-Nursing and personal support services
-Dietary services and hydration
-Accommodation services
-Falls prevention and management program
-Skin and wound care program
-Continence care and bowel program
-Pain management program

Record review revealed that many forms were available to monitor and assess the residents but their use was inconsistent as there was little direction of when or how to use them. As well, referrals were not always being made to specialists when required as evidenced by a lack of referral to the dietitian for poor intake and wound care. Interview with the acting Administrator and DOC confirmed that if structured programs were in place with specific policies and procedures, there would be better guidance for staff and improved outcome for residents.

During this inspection the inspectors found no evidence that the above mentioned programs were being evaluated and updated. Interview with the DOC confirmed that no annual evaluations of programs occur. (501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 10, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA s.76(2) to ensure that all staff receive training in the area of mandatory reporting under section 24 of the Act prior to performing their responsibilities.
The plan must include a training program to be provided for all staff prior to performing their responsibilities that includes all areas as outlined in s.76(2) of the Act.
The plan is to be emailed to susan.semeredy@ontario.ca by December 10, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that staff receive training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities.

Review of the document titled "Orientation - Facility" dated January 1, 2011, found no reference to training on mandatory reporting under section 24 of the Act . Interviews with the DOC and acting Administrator revealed they are responsible for staff training and follow the "Orientation- Facility" document in order to provide training. The DOC and acting Administrator confirmed the home does not provide staff with training on mandatory reporting under section 24 of the Act. (555)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 10, 2015

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA s.76(4) to ensure that all staff receive retraining annually related to the Resident's Bill of Rights, zero tolerance of abuse and neglect, mandatory reporting under section 24 and whistle-blowing protection.
The plan must also include a training program that provides retraining for staff that have received training in all the areas mentioned in section 76(2) at times or at intervals provided for in the regulations.
The plan is to be emailed to susan.semeredy@ontario.ca by December 10, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff receive retraining annually related to: the Resident's Bill of Rights; zero tolerance of abuse and neglect; mandatory reporting under section 24; and whistle-blowing protection.

Review of staff training records provided for 2013 found 52 per cent of staff members did not receive retraining related to the Residents' Bill of Rights; there was no evidence at all of retraining related to zero tolerance of abuse and neglect, mandatory reporting and whistle-blowing protection.

Interview with the acting Administrator confirmed the above numbers and reported there are no other training records available related to zero tolerance of abuse, mandatory reporting or whistle-blowing protection for 2013.

(555)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 10, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 26th day of November, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Susan Semeredy

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