Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Apr 13, 2015	2015_275536_0006	H-002111-15	Resident Quality Inspection

Licensee/Titulaire de permis

MISSISSAUGA LONG TERM CARE FACILITY INC.
26 PETER STREET NORTH MISSISSAUGA ON L5H 2G7

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

MISSISSAUGA LONG TERM CARE FACILITY
26 PETER STREET NORTH MISSISSAUGA ON L5H 2G7

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

CATHIE ROBITAILLE (536), BERNADETTE SUSNIK (120), DARIA TRZOS (561), KATHLEEN MILLAR (527), MICHELLE WARRENER (107)

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): March 12, 13, 16, 17, 18, 19 and 20, 2015.

During the course of the inspection, the inspector(s) spoke with residents, family, regulated and unregulated workers, Registered staff, dietary staff, Cook, Food Service Supervisor, Maintenance, Assistant to the Administrator/Supervisor of Housekeeping & Laundry Services, Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector(s) toured the home, observed care and services, reviewed clinical records, business files and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

17 WN(s)
6 VPC(s)
1 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. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee has failed to ensure that the lighting requirements set out in the lighting table were maintained.

The lighting requirements as set out in the lighting table were not maintained. A variety of lighting fixtures on all floors were measured, however not all areas were tested. Those that were tested are listed below. Only 3 different types of resident rooms were measured (single, double and triple bed rooms) as all had similar lighting fixtures in style and number. Light fixtures were measured using a portable digital light meter, held 30 inches above and parallel to the level of the floor. Outdoor lighting conditions were bright at the time of measurement and all efforts were made to close blinds and drapery to

block out the natural light.

Corridors

Corridor lights were equipped with double strip 4 foot fluorescent tubes with opaque lens covers with the exception of two bulb dome lights with opaque covered lens located in the hallways closest to the elevator.

Corridor lights in the basement directly under the florescent tube lights, ranged in illumination levels between 124 and 212 lux. Under the two bulb dome light located outside the sprinkler room the illumination level was 235 lux. Levels between the fixtures were measured to be between 50 and 150 lux, depending on the span between fixtures. The sitting area outside the laundry room, there was a three light chandelier. Walking between the coffee table and the couch, was 175 lux.

Corridor lights on the 1st floor, directly under the lights, illumination levels ranged between 40 and 190 lux. Levels between the fixtures were measured to be between 30 and 190 lux, depending on the span between fixtures.

Corridor lights on the 2nd floor, directly under the lights, illumination levels ranged between 60 and 210 lux, with the exception of the fluorescent light outside the stairwell by the dining room which had an illumination level of 440 lux. Levels between the fixtures were measured to be between 30 and 89 lux, depending on the span between fixtures.

None of the corridors had the required consistent and continuous lux of 215.28.

Dining Rooms

The basement dining room/activity area was equipped with 3 double strip 4 foot fluorescent tubes with opaque lens covers, above each table. Directly under the lights, the lux ranged in illumination levels between 200 and 233 lux. Levels between the fixtures were measured to be between 50 and 150 lux, depending on the span between fixtures. The activity area was equipped with one compact ceiling fan with 4 lights located above 2 sofas. Directly under the light was 454 lux.

The 1st floor dining room, was equipped with four flush mount dome lights each with 2 bulbs and an opaque covered lens. Directly under the lights, illumination levels ranged

between 115 and 155 lux. Levels between the fixtures were measured to be between 65 and 85 lux.

The 2nd floor dining room located outside of room 210, was equipped with 3 hanging flush mount dome lights each with 2 bulbs and an opaque lens covers, and one fan with a 1 bulb hanging light. Directly under the dome lights, illumination levels ranged between 145 and 198 lux. Directly under the fan light was 140 lux. Levels between the fixtures were measured to be between 100 and 120 lux.
A minimum level of 215.28 lux is required in dining rooms.

Stairwells

The stairwell located by the kitchen, was measured and it was noted that on the 1st floor landing that 1 light bulb of the double strip 4 foot fluorescent tubes with opaque lens covers was burnt out. Directly under the light, the levels ranged in illumination levels between 150 and 175 lux. In the same stairwell on the 2nd floor landing, directly under the light, ranged in illumination levels ranged between 225 and 285 lux. A minimum level of 322.92 lux is required.

Bedrooms

Resident rooms on the 1st and 2nd floor (with the exception of room #201) were each equipped with room had one flush mounted two bulb fixture with an opaque glass lens and an over-bed light. On the 1st floor room #104; a semi-private room, directly under the light in the center of the room was 235 lux. Under bed-A, over-bed light was 530 lux. Under Bed-B, over-bed light was 530 lux. Without the over-bed light it was 160 lux. In a private room #106, directly under the light in the center of the room, it was 220 lux. The path of travel between the center of the room and the bed was 120 lux. Over the sink in room #106 was 120 lux.

On the 2nd floor room #201; a semi-private room with a bulk head between the two beds there was one single bulb light with an opaque glass shade in the center of the room and an over-bed light above each bed. With the over-bed lights on, the entrance to the room ranged in illumination levels between 50 to 100 lux. The path of travel towards the light was 120 lux. In a three-bed room #203, with the over-bed lights on, between bed-B and bed-C was 150 lux. Between bed-A and bed-B was 95 lux. A minimum of 376.73 lux is required for over-bed lighting, and 215.28 lux in the bedrooms path of travel is required.

A minimum level of 215.28 lux is required in all bedrooms for general room light.

Washrooms

Common washrooms on the 1st floor were equipped with square shaped flush mounted fixtures with florescent bulbs that were measured and ranged in illumination levels between 85 and 170 lux. The shower by room #111 which had no lens cover, was 195 lux.

Common washrooms on the 2nd floor had a variety of lighting fixtures. Common washroom #1 was 130 lux under the fixture and 63 lux in the shower area. Common bathroom #2 was 72 lux under the light. Common bathroom #4, was 125 lux under the light. A minimum of 215.28 lux is required in washrooms.

The licensee hired a contractor to complete the upgrades to the lighting levels in the corridors only however, the work had not started at the time of the inspection and no work plan had been submitted to the Ministry of Health and Long Term Care, Capital Investment Branch for prior approval. [s. 18.]

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. 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 has failed to ensure that the following rights of residents were 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.

A) On March 16, 2015 at 1345 hours, the LTC Inspector was walking past an identified room. The LTC Inspector observed the Personal Support Workers (PSW's), returning resident #043 to bed using the mechanical lift. The door to the resident's room was fully open, and there were no privacy curtains drawn. One of the PSW's saw the inspector and pulled the privacy curtain half way across, however it did not provide privacy for the resident.

B) On March 16, 2015 at 1430 hours, the LTC Inspector observed resident #015 being transferred from bed to wheelchair by two PSW's using the mechanical lift. The door to the resident's room was left fully open, and the resident's buttocks were exposed. The PSW's confirmed they did not provide privacy for either resident while providing care. The staff also confirmed they were aware they were expected to use the privacy curtains, or close the residents' room door. [s. 3. (1) 8.]

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 and ensuring that every resident has the right to be afforded privacy, to be implemented voluntarily.

WN #3: 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:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
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).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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 did not ensure that all doors leading to stairways were kept locked, equipped with a door access control system (that is kept on at all times), connected to

the resident staff communication and response system (enunciator panel) or equipped with an audible door alarm at each door that allowed any door breaches to be canceled only at the point of activation.

A)The lowest level of the home was accessed by residents on a regular basis for dining and activities. The area was accessible by elevator and two stairwells, one on the north side of the building and one on the south side of the building. The north side stairwell was equipped with two access doors and the south side stairwell only one access door. These doors did not have an access control system (some form of locking mechanism), alarm at the door or were connected to the resident staff communication and response system. Discussion was held at the time of inspection (March 20, 2015) with an electrical contractor who was hired by the licensee, to the requirements of the legislation. Clarification was made that the existing enunciator panel on the first floor was capable of supporting the installation of stairwell doors for both the lowest level and the first floor and that when the doors were breached, the location would be identified on the enunciator panel and an alarm would sound on the 1st floor as well as at the door locations in the lowest level.

B)The north and south stairwell doors located on the 1st and 2nd floors were equipped with a door access control system but were not equipped with an audible alarm at the door or were connected to the resident-staff communication and response system (enunciator panel). The electrical contractor was informed that the requirement was to connect the 3 doors to the 2 stairwells on the 2nd floor to the enunciator panel on the 2nd floor and the 3 doors to the 2 stairwells on the 1st floor would be connected to the enunciator panel on the first floor. As the south side stairwell doors on 1st and 2nd floor were within 6 feet of the enunciator panel, a separate door alarm would not be necessary.

C)At the time of inspection, residents had access to all stairwells and were therefore able to access two doors to unsecure outdoor areas as well as two front doors. None of the doors were equipped with door alarms. However, once the licensee equips the stairwell doors with a door access control system, residents will no longer be able to access the exit doors to the outside. Therefore, only two front doors to which residents will have access will be required to have door alarms located at the doors. [s. 9. (1)]

2. The licensee did not ensure that all doors leading to non-residential areas were kept locked.

On March 19, 2015, the door to the furnace room, which was equipped with a lock was found unlocked in the morning between 9:30 a.m. and 10 a.m.. The door was locked by the inspector. A few hours later, the door was found unlocked. The maintenance person was informed that doors leading to areas such as laundry rooms, furnace or mechanical rooms and staff rooms were to remain locked when not occupied by staff. [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 stairways and to unenclosed outdoor areas of the home are kept closed and locked, equipped with a door access control system that is kept on at all times and equipped with an audible door alarm that allows calls to be canceled only at the point of activation, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the resident-staff communication and response system was available in every area accessible by residents.

Activation stations were not provided in the lower level dining area, 1st floor dining area or the 2nd floor lounge room (formerly a dining room). [s. 17. (1) (e)]

2. The licensee did not ensure that the home was equipped with a resident-staff communication and response system that in the case of a system that uses sound to alert staff, was properly calibrated so that the level of sound was audible to staff.

The sound system for the home's resident-staff communication and response system was located at one central point, at the audio visual enunciator panel at each of the two nurses' stations. No sound speakers were equipped in any of the corridors in order to equalize the sound (thereby reducing the level of sound at the enunciator panel). The sound was overly loud at the nurse's station, adding an unnecessary distraction and annoyance for residents who were sitting in the dining room across from the nurse's station and for residents who have their bedrooms nearby. The audibility was tested at the furthest point from the enunciator panel and around a corner, in a resident room. The sound level was barely audible, especially when the door was closed, which would be the case if staff were providing care to residents. [s. 17. (1) (g)]

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 and ensure that the resident-staff communication and response system is available in every area accessible by residents and ensuring that the resident-staff communication system is properly calibrated so that the level of sound is audible to staff, to be implemented voluntarily.

WN #5: 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. (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 all staff have receive retraining annually relating to the following:

- The Residents' Bill of Rights;
- The home's policy to promote zero tolerance of abuse and neglect of residents;
- The duty to make mandatory reports under section 24; and
- The whistle-blowing protections.

The Director of care (DOC) was interviewed on March 17 and 18, 2015, and was not able to provide documentation to reflect that all staff had been retrained on the Residents' Bill of Rights; the home's policy to promote zero tolerance of abuse and neglect of residents; the duty to make mandatory reports under section 24; and the whistle-blowing protections. On March 17 and 18, 2015, the registered staff, Personal Support Workers (PSW's) and housekeeping aides were interviewed, and they identified that they were usually trained on the prevention of abuse and neglect annually; however, they were unable to recall if they received any training in 2014. There were only 24 out of 64 of the

home's staff retrained in 2014. The home's training records and the DOC confirmed that not all staff had received annual retraining in the prevention of abuse and neglect. [s. 76. (4)]

2. The licensee did not ensure that all staff who provide direct care to residents received, 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: 6. Any other areas provided for in the regulations.

1)Regulation 221(1)1, requires training for all staff who provide direct care to residents related to falls prevention and management. Regulation 221(1)3, requires training for all staff who provide direct care to residents related to continence care and bowel management.

2)Regulation 221(2)1, requires that all staff who provide direct care to residents receive the training provided for in subsection 76(7) of the Act based on the following: Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76(7) of the Act.

-Training records for 2014, identified that 13 out of 47 direct care staff attended training on continence care and bowel management.

-Training records for 2014, identified that 12 our of 47 direct care staff attended training on fall prevention.

The Director of Care confirmed that not all direct care staff received the required training. [s. 76. (7) 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 and ensuring that all staff receive retraining annually according to the legislative requirements, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee did not ensure that as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, there were schedules and procedures in place for preventive maintenance.

A) On March 19, 2015, a general tour of the home was completed and numerous floor tiles were observed to be cracked in the 1st floor dining room, entrance area into the 2nd floor dining room, 1st floor corridor (in front of south stairwell door, bath room #3 and dumb waiter) and on 2nd floor corridor (in front of south stairwell door, in front of room 206 and across the width of hall near room 211). According to the maintenance person, floor tiles have been replaced in the past and typically in the warmer months of the year.

The licensee's preventive maintenance procedures did not include any direction for staff with respect to floor condition standards, who and how often the floors would be inspected and what follow up actions could be taken. The licensee did not have any schedules in place to address the floor condition at the time of inspection.

B) On March 19, 2015, a review of the home's furnishings, window casings and baseboards was completed and some noted to be worn down to raw wood. Dressers located in rooms 104, 110 and 207 had top surfaces that were not sealed, the varnish had worn down. The wooden cabinet doors (edges) were no longer smooth or could be cleaned in washroom #4 on 1st floor, the 1st floor shower room had a wood shelf that was in poor condition and window casings that were not sealed.

The licensee's preventive maintenance procedures did not include any direction for staff with respect to condition standards for furnishings, wood casings, baseboards etc., who and how often the surfaces and furnishings would be inspected and what follow up actions could be taken. The licensee did not have any schedules in place to address the condition of the furnishings, casings and baseboards at the time of inspection.

Discussion was held at the time of the inspection with the acting Administrator and Food Services Supervisor/Policy Developer regarding the current maintenance program (forms, policies and templates) and further developing it to ensure that all interior areas of the home be audited on a regular basis to ensure they are maintained in good condition. [s. 90. (1) (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 and ensure that there are schedules and procedures in place for preventative maintenance, to be implemented voluntarily.

WN #7: 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 has failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

On March 12, 2015 during a tour of the home, it was observed by the LTC Inspector that the door to the closet in an identified bathroom was unlocked, and the bathroom door was wide open. Inside the closet, the inspector found a "bathroom cream cleanser" and other clear bottles with liquid that were unlabelled. The Personal Support Workers (PSW's) on the unit confirmed, that the solution in the clear bottles was used to clean the bathrooms. The PSW also confirmed that the closet doors should have been locked at all times. [s. 91.]

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 and ensure that all hazardous substances are properly labelled and kept inaccessible to residents, to be implemented voluntarily.

WN #8: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #016 set out clear directions to staff and others who provided direct care to the resident.

A) Resident #016's care plan (the document staff used to provide directions related to care)related to bowel management directed staff to increase fluid intake, provide high fibre foods, and eliminate foods causing adverse effects for constipation. During interview, Personal Support Worker(PSW) staff stated they were unsure of what foods they would provide for high fibre, as the resident required a renal diet with white bread and cereals (no whole wheat), and was on a fluid restriction. Direction on the care plan directing staff to increase fluids was also unclear in relation to the resident's fluid restriction.

B) Resident #016's care plan related to dehydration, also directed staff to increase fluid intake during hot months. The resident required a fluid restriction, and had a specific plan in place related to provision of fluids at meals and snacks. Direction was not clear related to quantity of fluids to increase in relation to the resident's fluid restriction.

C) The front section of resident #016's care plan "Health Conditions" identified the resident's dialysis treatments were on hold (physician's orders also confirmed the resident was no longer receiving dialysis); however, the "GU" section of the care plan also directed staff to have the resident ready for transportation on dialysis days and was scheduled for every Tuesday, Thursday and Saturday. The plan had not been revised to remove that direction, resulting in unclear and conflicting directions for staff. [s. 6. (1) (c)]

WN #9: 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 has failed to ensure that the "Fall Prevention and Risk Management" policy, revised January 25, 2012, and reviewed December 9, 2014, was not complied with by staff.

A) The policy stated that registered staff would, "Conduct the Falls Risk Assessment in Point of Care (POC) at the following times: within 24 hours of admission or re-admission; when there is a physiological, functional or cognitive change in status; quarterly; recent falls; annually".

Resident #016 had documented falls on identified dates in 2015. The Falls Risk Assessment was completed on identified dates in 2014, and again in 2015, at the quarterly review. The Falls Risk Assessment form was not completed as specified in the home's policy.

B)The policy stated that registered staff would, "Conduct the Falls Risk Assessment in POC at the following times: within 24 hours of admission or re-admission; when there is a physiological, functional or cognitive change in status; quarterly; recent falls; annually".

Resident #018 had documented falls on an identified dates in 2015. The Falls Risk Assessment was completed in 2015, at the quarterly review but, was not completed for either fall in 2015, as specified in the home's policy.

The Director of Care (DOC) confirmed that the Falls Risk Assessment tool was the tool under the "assessment" section in MediCare. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

A) The home's policy, "Food Service Temperatures", revised December 9, 2011, and reviewed April 23, 2014, stated that "once all food is transported to the servery, prior to serving foods, take the temperature of all foods and record them on the Temperature Control Record".

B) In an identified dining room at noon meal service on March 12, 2015, staff did not take the temperature of the texture modified menu items prior to service. The Dietary Aide confirmed, that only the temperature of the regular texture items was taken and recorded. Staff stated that they always took the temperature of only the regular textured items, because that was the way it was always done.

C) Food was prepared in the kitchen and portioned into small containers, that were placed on an uninsulated cart that was used to transport the food containers to the different serveries, where they were placed into the hot steam tables. The containers of food were noted to be sitting for a short time on the carts while staff were getting their supplies ready. Containers for the texture modified items were smaller and would have more heat transfer/loss. Temperatures of foods were not monitored prior to service to ensure temperatures were maintained, safe (not too hot) and palatable. [s. 8. (1) (b)]

WN #10: 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. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that at a minimum, the policy to promote zero tolerance of abuse and neglect of residents, (d) shall contain an explanation of the duty under section 24 to make mandatory reports.

The home's policy and procedure called "Zero Tolerance Policy: Abuse and Neglect", revised February 28, 2012, reviewed August 6, 2014, does not contain an explanation of the duty under section 24 to make mandatory reports. On page 253, paragraph two and under the Heading "Reporting to the Ministry of Health and Long Term Care" it states: "The Director of Care or designate will complete an Critical Incident Reporting Form and submitted to the Ministry Regional Office within five days of discovering that abuse has taken place." In addition, on page 255, #12 of the procedure for "Resident Abuse by Formal Caregiver or Volunteer", it states: "The Director of Care or designated shall ensure that the incident is reported to the Ministry of Health and Long Term Care Compliance Advisor or Regional Office and Assured Care Consultant within 24 hours." In an interview on March 18, 2015, the Director of Care confirmed that the home's policy was not up to date and did not specify that the reporting to the Director was immediate once the person had reasonable grounds to suspect abuse of a resident by anyone. [s. 20. (2)]

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. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care included the consent by the substitute decision maker.

Resident #034 was cognitively impaired and was observed on identified dates in 2015, restrained using a tilt wheelchair to prevent rising. There was no consent on the resident's clinical record from the substitute decision maker, for the tilt wheelchair. There was a consent for the use of a seat belt. The registered staff were interviewed on March 18, 2015, and after a review of the clinical record, the registered staff confirmed that there was no consent on the resident's clinical record. [s. 31. (2) 5.]

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

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the continence care and bowel management program included an annual resident satisfaction evaluation of continence care products in consultation with residents, substitute decision-makers and direct care staff.

The DOC confirmed that the home does not currently have a formalized process for obtaining resident satisfaction related to continence care products annually. [s. 51. (1) 5.]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to ensure that they consult regularly with the Residents' Council at least every three months.

The inspector was unable to confirm when speaking with the President of the Residents' Council, or following a review of the Resident's Council minutes for 2014, that the home had consulted regularly, or at least every three months with the Residents' Council. On March 23, 2015 the Director of Care, who was covering for both the Administrator and the Activation Co-Ordinator, was unable to confirm this had occurred. [s. 67.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining and snack services, included a review of the meal and snack times by the Residents' Council.

The inspector was unable to confirm when speaking with the President of the Residents' Council, or following a review of the Resident's Council minutes for 2014, that meal and snack times had been reviewed with the Residents' Council. This was confirmed by the Food Service Supervisor on March 20, 2015. [s. 73. (1) 2.]

WN #15: 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 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, and what changes and improvements are required to prevent further occurrences.

The home was unable to provide an evaluation to determine the effectiveness of the policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvement were required to prevent further occurrences. The Director of Care (DOC) was interviewed on March 17 and 18, 2015, and was unable to provide an evaluation. The Food Service Supervisor (FSS) who was responsible for the home's policies, was also interviewed and confirmed that they did not complete an evaluation of their policy to determine its effectiveness and what changes would be made to improve the policy's effectiveness. Both the DOC and the FSS identified during the interview with the inspector, were the policy was confusing and/or didn't align with the Long Term Care Homes Act (LTCHA). [s. 99. (b)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) the documented record (of complaints received) is reviewed and analyzed for trends, at least quarterly; (b) the results of the review and analysis are taken into account in determining what improvements are required in the home, and (c) a written record is kept of each review and of the improvements made in response.

The home's policy and procedures for "Reporting and Complaints" revised February 28, 2012, and reviewed October 19, 2014, does not include a written record of complaints received and analyzed for trends at least quarterly. The home documents all of the complaints in the resident's clinical record, from the time the complaint or concern was received, until it was resolved. The Director of Care (DOC) identified that the home had never received a written formal complaint, and that their complaints were either verbal or by telephone. The home then transfers that information obtained from the complainant to the resident's clinical record. The home was unable to provide any information as a result of their review, analysis and/or improvements implemented related to their complaints and concerns received. The DOC and the Food Service Supervisor (FSS) confirmed, that the home did not keep a written record of their complaint reviews, their quarterly analysis, or any improvements made in response to complaints. [s. 101. (3)]

WN #17: 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. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the physical device was applied in accordance with the manufacturer's instructions.

A)Resident #034 was observed wearing a seat belt on March 16, 2015. The resident's seat belt was very loose, and the LTC Inspector was able to fit two hands between the seat belt and the resident's body. The Personal Support Workers (PSW's) and the registered staff confirmed, that the resident was unable to unlock the seat belt, and that the seat belt was applied incorrectly. The PSW's and registered staff were unaware and unable to locate the manufacturer's instructions for correct application. The home's policy called "Restraining by a Physical Device", revised December 9, 2014, on page 293 confirmed that staff were expected to apply the physical device in accordance with the manufacturer's instructions.

B)Resident #037 was observed wearing a seat belt on March 16, 2015. The resident's seat belt was very loose, and the LTC Inspector was able to fit two hands between the seat belt and the resident's body. The PSW's and the registered staff confirmed, the resident was unable to unlock the seat belt, and the seat belt was applied incorrectly. The PSW's and registered staff were unaware and unable to locate the manufacturer's instructions for correct application. The home's policy called "Restraining by a Physical Device", revised December 9, 2014, on page 293 confirmed that staff were expect to apply the physical device in accordance with the manufacturer's instructions. [s. 110. (1) 1.]

Issued on this 22nd day of April, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CATHIE ROBITAILLE (536), BERNADETTE SUSNIK (120), DARIA TRZOS (561), KATHLEEN MILLAR (527), MICHELLE WARRENER (107)
Inspection No. / No de l'inspection :	2015_275536_0006
Log No. / Registre no:	H-002111-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 13, 2015
Licensee / Titulaire de permis :	MISSISSAUGA LONG TERM CARE FACILITY INC. 26 PETER STREET NORTH, MISSISSAUGA, ON, L5H-2G7
LTC Home / Foyer de SLD :	MISSISSAUGA LONG TERM CARE FACILITY 26 PETER STREET NORTH, MISSISSAUGA, ON, L5H-2G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

To MISSISSAUGA LONG TERM CARE FACILITY INC., 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. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Order / Ordre :

The licensee shall submit a completed form titled "Operator's Guide to the Process for Alterations, Renovations or Additions to existing Long Term Care Homes" to the Ministry of Health and Long Term Care, Planning and Renewal Branch for any major lighting upgrades in the home. Once approval is granted, the licensee shall prepare and submit a plan that summarizes how the lighting deficiencies in the various identified areas of the home will be addressed, the time frames for completion and who will complete the work.

The plan shall be submitted to Bernadette.susnik@ontario.ca by July 30, 2015. The plan shall be fully implemented by July 30, 2016.

Grounds / Motifs :

1. Previously issued as a VPC November 8, 2013.

2.The lighting requirements as set out in the lighting table were not maintained. A variety of lighting fixtures on all floors were measured, however not all areas were tested. Those that were tested are listed below. Only 3 different types of resident rooms were measured (single, double and triple bed rooms) as all had similar lighting fixtures in style and number. Light fixtures were measured using a portable digital light meter, held 30 inches above and parallel to the level of the floor. Outdoor lighting conditions were bright at the time of measurement and all efforts were made to close blinds and drapery to block out the natural light.

A) Corridors

Corridor lights were equipped with double strip 4 foot fluorescent tubes with opaque lens covers with the exception of two bulb dome lights with opaque covered lens located in the hallways closest to the elevator.

Corridor lights in the basement directly under the florescent tube lights, ranged in illumination levels between 124 and 212 lux. Under the two bulb dome light located outside the sprinkler room the illumination level was 235 lux. Levels between the fixtures were measured to be between 50 and 150 lux, depending on the span between fixtures. The sitting area outside the laundry room, there was a three light chandelier. Walking between the coffee table and the couch, was 175 lux.

Corridor lights on the 1st floor, directly under the lights, illumination levels ranged between 40 and 190 lux. Levels between the fixtures were measured to

be between 30 and 190 lux, depending on the span between fixtures.

Corridor lights on the 2nd floor, directly under the lights, illumination levels ranged between 60 and 210 lux, with the exception of the fluorescent light outside the stairwell by the dining room which had an illumination level of 440 lux. Levels between the fixtures were measured to be between 30 and 89 lux, depending on the span between fixtures.

None of the corridors had the required consistent and continuous lux of 215.28.

B) Dining Rooms

The basement dining room/activity area was equipped with 3 double strip 4 foot fluorescent tubes with opaque lens covers, above each table. Directly under the lights, the lux ranged in illumination levels between 200 and 233 lux. Levels between the fixtures were measured to be between 50 and 150 lux, depending on the span between fixtures. The activity area was equipped with one compact ceiling fan with 4 lights located above 2 sofas. Directly under the light was 454 lux.

The 1st floor dining room, was equipped with four flush mount dome lights each with 2 bulbs and an opaque covered lens. Directly under the lights, illumination levels ranged between 115 and 155 lux. Levels between the fixtures were measured to be between 65 and 85 lux.

The 2nd floor dining room located outside of room 210, was equipped with 3 hanging flush mount dome lights each with 2 bulbs and an opaque lens covers, and one fan with a 1 bulb hanging light. Directly under the dome lights, illumination levels ranged between 145 and 198 lux. Directly under the fan light was 140 lux. Levels between the fixtures were measured to be between 100 and 120 lux.
A minimum level of 215.28 lux is required in dining rooms.

C) Stairwells

The stairwell located by the kitchen, was measured and it was noted that on the 1st floor landing that 1 light bulb of the double strip 4 foot fluorescent tubes with opaque lens covers was burnt out. Directly under the light, the levels ranged in illumination levels between 150 and 175 lux. In the same stairwell on the 2nd

floor landing, directly under the light, ranged in illumination levels ranged between 225 and 285 lux. A minimum level of 322.92 lux is required.

D) Bedrooms

Resident rooms on the 1st and 2nd floor (with the exception of room #201) were each equipped with room had one flush mounted two bulb fixture with an opaque glass lens and an over-bed light. On the 1st floor room #104; a semi-private room, directly under the light in the center of the room was 235 lux. Under bed-A, over-bed light was 530 lux. Under Bed-B, over-bed light was 530 lux. Without the over-bed light it was 160 lux. In a private room #106, directly under the light in the center of the room, it was 220 lux. The path of travel between the center of the room and the bed was 120 lux. Over the sink in room #106 was 120 lux.

On the 2nd floor room #201; a semi-private room with a bulk head between the two beds there was one single bulb light with an opaque glass shade in the center of the room and an over-bed light above each bed. With the over-bed lights on, the entrance to the room ranged in illumination levels between 50 to 100 lux. The path of travel towards the light was 120 lux. In a three-bed room #203, with the over-bed lights on, between bed-B and bed-C was 150 lux. Between bed-A and bed-B was 95 lux. A minimum of 376.73 lux is required for over-bed lighting, and 215.28 lux in the bedrooms path of travel is required.

A minimum level of 215.28 lux is required in all bedrooms for general room light.

E) Washrooms

Common washrooms on the 1st floor were equipped with square shaped flush mounted fixtures with florescent bulbs that were measured and ranged in illumination levels between 85 and 170 lux. The shower by room #111 which had no lens cover, was 195 lux.

Common washrooms on the 2nd floor had a variety of lighting fixtures. Common washroom #1 was 130 lux under the fixture and 63 lux in the shower area. Common bathroom #2 was 72 lux under the light. Common bathroom #4, was 125 lux under the light. A minimum of 215.28 lux is required in washrooms.

The licensee hired a contractor to complete the upgrades to the lighting levels in

the corridors only however, the work had not started at the time of the inspection and no work plan had been submitted to the Ministry of Health and Long Term Care, Capital Investment Branch for prior approval.

(536)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 30, 2016

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 13th day of April, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cathie Robitaille

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