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
Jan 30, 2015	2014_293554_0039	O-001362-14	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

THORNTONVIEW
186 THORNTON ROAD SOUTH OSHAWA ON L1J 5Y2

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

KELLY BURNS (554), GWEN COLES (555), KARYN WOOD (601), LYNDA BROWN (111), MARIA FRANCIS-ALLEN (552), MATTHEW STICCA (553)

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): December 15-19, 22-23, 29-31, 2014 and January 02, 2015

During the course of this Resident Quality Inspection, the following concurrent intakes were completed: #O-000135-14, O-000737-14, O-000803-14, O-000817-14, O-000864-14, O-000911-14, O-001350-14, O-001353, O-001357-14, and O-001388-14

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Nutritional Care Manager, Environmental Services Manager (ESM), Office Manager, RAI-Coordinator/Behaviour Support Coordinator, Staff Educator, Registered Nurse(s) (RN), Registered Practical Nurse(s)(RPN), Personal Support Worker(s)(PSW), Dietary Aide(s)(DA), Housekeeper(s), Maintenance Worker, Resident(s), and Family

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

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

16 WN(s)
6 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Related to Log #O-001388-14, for Resident #56:

The licensee failed to comply with O. Reg. 79/10, s. 36, by ensuring that staff use safe transferring and positioning devices or techniques when assisting residents.

The Director of Care submitted a Critical Incident Report(CIR), on a specific date, relating to an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status.

Details of the incident are as follows:
- Personal Support Worker (PSW) was providing care to Resident #56, while resident was seated on a mechanical lift. According to the CIR, PSW stated he/she was reaching for another mechanical lift, when Resident #56 leaned forward and fell to the floor.

According to the CIR details, no initial injury was noted by the registered nursing staff who assessed resident. Approximately two hours later, Resident #56 began complaining of discomfort; resident was transferred to hospital for assessment and was admitted due to injuries sustained, as a result of the fall.

Representatives from the home (Executive Director and Director of Care) initiated an investigation into the cause of why and how resident fell.

According to the home's investigation notes, Staff #122 had been in the room just prior to Resident #56 falling from the mechanical lift and indicated in his/her witness statement being aware that Staff #130 was not using the safety belt nor the safety arm (bar) while operating the mechanical lift; staff #122 further indicated that no second staff was present when he/she left the room.

Staff #122 indicated in his/her statement that it was 'common practice' for staff to remove the safety belt from the specific mechanical lift, while resident still on the lift, as the belt

was cold for resident's when wet.

The Director of Care indicated that the investigation concluded that Staff #130 did not follow the home's Safe Lift and Transfer policies by failing to: a) not having two staff present during the operation of mechanical lift, b) not using safety belt on mechanical lift, and c) not having the safety arm/bar engaged when resident was on the mechanical lift.

Director of Care indicated Staff #130 was disciplined as a result of not following the home's Safe Lifting and Transferring policies. DOC indicated no discipline was issued to Staff #122, despite staff having knowledge of safety measures not in place prior to the incident occurring.

The home's policy, Bath Lifts, Tub Chairs and Shower Commodes (LTC-K-80) directs the following:
- Seatbelts/protective bar will be applied at all times while the Resident is sitting on the bath chair
- Two staff members will be present during the lifting and lowering of a Resident in a mechanical bathing device
- All equipment must be utilized in accordance with manufacturer's specifications

A poster posted on the spa room wall indicates the specific mechanical lift in use at the time of the incident requires the use of the safety belt and the safety bar to be in place while resident is on the mechanical lift.

The home's Safety in Ambulating, Lifting and Transferring Program Policy (HS16-P-10) directs that two staff will be present at all times while the mechanical device is in operation.

Staff #122 indicated, in an interview during the inspection, that if the safety belt, for the mechanical lift, is available then the safety belt would be used while bathing residents; staff did indicate that the safety belt is often missing and there is only one safety belt per spa room available. Staff indicated that the home has just ordered more safety belts following the incident involving Resident #56.

Staff #122 indicated that it's a common practice to remove the safety belt when resident is taken out of tub, but still sitting on the bath chair/lift as the wet, cold belt triggers responsive behaviours of some residents.

Staff #129 indicated that two staff are only present when a resident is transferred with mechanical lift from wheelchair to mechanical (bath) lift and from mechanical (bath) lift into wheelchair; staff indicated that there is only one staff member present when a resident is lifted out of the tub using the bath chair/lift and while resident is sitting on the mechanical (bath) lift being dried.

Director of Care indicated it is the expectation that the safety belt be used whenever a resident is on the specific mechanical (bath) lift, that the safety arm/bar be is to be in place when the lift is in use and that two staff are at all times to be present when the lift is operational. [s. 36.]

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. 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. Related to Log #O-000737-14, for Resident #61:

The licensee failed to ensure that Resident #61 was not neglected by the licensee or staff.

Under the LTCHHA, 2007, s. 5. neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A critical incident report(CIR) was received on a specific date, for an incident of staff to resident neglect that occurred. The CIR indicated Resident #61 was placed on the toilet

with a sit to stand transfer aide by staff; the report indicates staff did not inform the next shift. The resident was found on the toilet approximately 2 hours later. The resident was returned to bed and assessed; resident was noted to have altered skin integrity as a result.

Review of the care plan for Resident #61(in place prior to incident) related to toileting indicated the resident requires support to provide toileting as evidenced by inability to complete task safely and independently due to: impaired cognition and physical limitations. Interventions included: requires assistance with toileting tasks, use Sit to Stand transfer aid to transfer on/off toilet/commode.

Review of the homes policy "Safety In Ambulating Lifting and Transferring Program" (HS16-O-12) indicated on page 2 of 4 that two staff will always be present during the operation of the mechanical device, one staff acting as the leader and the other assisting with Resident/client safety.

Review of the resident's health record, the home's investigation, internal incident report, and interview of the DOC indicated the PSW assigned to Resident #61 on a specific date and shift was the staff member who transferred Resident #61 onto a toilet in the tub room with assistance of a co-worker. The resident was left on the toilet unattended, with the lift still attached, the door open, curtain pulled closed and the lights off. The DOC indicated the PSW left Resident #61 unattended on the toilet and did not report to oncoming shift. The PSW received disciplinary action as a result.

The licensee failed to ensure:
- the resident was not neglected by failing to ensure the written plan of care provided clear directions to staff as identified under WN #3 (for resident #61)
- staff failed to remain with the resident as per the home's policy
- staff failed to communicate to the oncoming shift that the resident was still on the toilet
- the oncoming shift failed to check on residents for approximately an hour
- the homes investigation only took actions towards the one staff who left the resident on the toilet but no actions were taken towards the oncoming shift [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 6 (1) (c), by ensuring that the plan of care set out clear directions to staff and others who provide direct care to the resident, specific to dental care/oral hygiene for Resident #15 and #28.

Related to Resident #28:

Resident #28 is dependent on staff for activities of daily living, specifically mouth care.

During an interview, Resident #28 indicated having a upper denture but no lower dentures (or natural teeth).

Staff #111 indicated Resident #28 has both upper and lower dentures; staff indicated that oral hygiene/dental care is provided twice daily. Staff #111 indicated dentures are brushed (cleaned) in the morning and are soaked overnight for this resident; staff indicated dentures maybe cleaned after meals if resident requests such.

Staff #100 indicated that the written plan of care should provide details specific to resident having own teeth or dentures and should include each individual resident's oral hygiene needs and assistance required .

The written care plan fails to provide clear direction as to if Resident #28 has dentures or

own teeth, frequency of dental or mouth care and staff assistance required.

Director of Care indicated that the written care plan should indicate the individual care needs of each resident, specifically if the resident has dentures or their own teeth, frequency of oral hygiene, and assistance required by staff. [s. 6. (1) (c)]

2. Related to Resident #15:

According to the written care plan, Resident #15 requires total support for all activities of daily living due to cognitive and or physical limitations.

During an interview, Resident #15 indicated having both upper and lower dentures and further stated dentures are brushed each morning by staff.

Resident was observed wearing upper denture (only) during two separate observations, despite resident indicating he/she had both upper and lower dentures.

Staff #110 indicated that Resident #15 only has upper denture (doesn't have lower denture or own teeth); staff indicated resident's denture is brushed each morning and that the denture is soaked overnight.

Staff #100 indicated that the written plan of care should provide details of a resident having dentures versus own teeth, as well as each individual resident's oral hygiene needs and staff assistance required.

The written plan of care (in place at time of inspection), for Resident #15, fails to provide clear direction as to if Resident #28 has dentures or own teeth, frequency of dental or mouth care and staff assistance required.

Director of Care indicated that the written care plan should indicate the individual care needs of each resident, specifically if the resident has dentures or their own teeth, frequency of oral hygiene, and assistance required by staff. [s. 6. (1) (c)]

3. Related to Log #O-000737-14, for Resident #61:

The licensee has failed to comply with LTCHA, 2007, s. 6 (1) (c), by ensuring that the plan of care set out clear directions to staff and others who provide direct care to the resident related to toileting.

Review of the homes investigational notes, interviews with the nursing staff, Director of Care and the Executive Director, and a review of the health care record of Resident #61 indicated that on a specific date and time, Resident #61 was transferred onto a toilet in the bathroom with two staff using a mechanical lift. The resident was left on the toilet with the mechanical lift still engaged for approximately two hours before staff on the next shift discovered the resident on the toilet. The staff members on the shift prior did not report to oncoming shift that the resident was still on the toilet.

Review of the care plan for Resident #61(in place prior to incident) relating to toileting/transfers, indicated the resident requires support to provide toileting as evidenced by inability to complete task safely and independently due to: impaired cognition and physical limitations. Interventions included: requires assistance with toileting tasks and to use transfer aid (lift) to transfer on/off toilet/commode.

Review of MDS indicated the resident required two staff assistance with mechanical lift for toileting.

Staff #122 indicated residents who require use of a mechanical lift are required to have staff present with the lift, but staff may leave the resident unattended on the toilet if the resident is capable of using the call bell; if the resident is not capable of using the call bell, then staff are to stay with the resident. Staff #120 indicated staff are to use two (2) staff to assist with all transfers using a mechanical lift and are to remain with the resident.

There was no clear direction to staff regarding whether the resident was able to use the call bell, or whether the resident was to remain on toilet unattended. There was no indication whether one or two staff were required. [s. 6. (1) (c)]

4. Related to Log #O-001388-14, for Resident #56:

The licensee failed to comply with LTCHA, 2007, s. 6 (1) (c), by ensuring the plan of care set out clear directions to staff and others who provide direct care to the resident relating to transfers.

Resident #56 fell and sustained injury; resident was transferred to hospital and was admitted due to injuries sustained from the fall.

Resident returned to the home, approximately two week later, requiring total assistance

with all aspects of care.

The written plan of care indicated the following:
- resident requires support for transfers as evidenced by inability to complete task on own due to impaired cognition and physical limitations; goal is to experience safe transfers. Interventions listed include, uses mechanical lift, all instructions and pictures showing transfer are posted in room.

A review of instructions and pictures posted over bed in resident's room specific to transferring Resident #56 indicated the following:
- transfer logo indicated resident is transferred using a mechanical sit-to stand lift
- information sheets posted indicated resident used a maxi mechanical lift while in hospital

Staff #129 indicated that a maxi lift was being used to transfer Resident #56 but did indicate that information posted above the resident's bed could be confusing to staff as two different transfer methods are indicated.

Staff # 120 and the Director of Care indicated that the written care plan should clearly identify which mechanical lift is to be used for the resident, and the transfer logo in Resident #56's room should have been updated on return from hospital to indicate that a mechanical maxi lift was to be used for this resident.

Based on the inconsistency between the plan of care, and transfer logo, there was no clear direction provided to staff specific to Resident #56's lift/transfer requirements post-hospitalization. [s. 6. (1) (c)]

5. Related to Resident #40:

The licensee has failed to comply with LTCHA, 2007, s. 6 (1) (c), by ensuring that the plan of care set out clear directions to staff and others who provide direct care to the resident, specific to pain management.

During interview the Resident #40 indicated that he/she had pain and that such is a chronic condition.

Staff #101 indicated, in an interview, that Resident #40 does complain of pain and receives scheduled analgesia.

A review of the medication administration records (MAR) indicated Resident #40 routinely receives two analgesics. Documentation on the MAR states that the resident is not permitted to receive additional analgesic due to being a maximum dosage requirements.

There is no documented evidence in the resident's written care plan surrounding the resident's issue with pain or pain management. [s. 6. (1) (c)]

6. Related to Log #O-000864-14, for Resident #60:

The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident related to elopement and smoking.

Review of the progress notes (during a six month time period) for Resident #60 indicated:

- Resident #60 was noted missing from the dining room at meal time. The RPN "thought the resident went to see a resident on another home area where he/she usually spends time". Forty minutes later the RPN went to the home area to locate the resident to give medications, but was unable to locate the resident. The RPN then checked the resident's room and the resident was not located. Staff then checked the entire unit and alerted other units and resident was not found. The POA was called and message left. Approximately two hours later the DOC was notified of the missing resident. The family member called back and indicated they had not seen the resident. DOC called a code yellow at that time. The Police and other managers were contacted. The resident was located by police and the resident was returned to the home without injury. Resident was informed that he/she was allowed to leave the home but he/she was to notify staff when he/she leaves for safety and "was placed on every safety observation". DOC met with POA to discuss concerns related to resident leaving facility; DOC informed POA that resident was able to make his/her own decisions and cannot prevent him/her at this time from leaving the facility.

Other dated entries (period of two months post incident) in Resident #60's health record:
- the resident attempted to leave the facility unsupervised and was redirected back inside. The resident was later seen sitting outside with another resident but returned by self.
- a staff member entering the home, found the resident sitting outside of the home. The staff member redirected back into the home as the resident's behaviour "was outside of

his/her norm".
- resident was found sitting outside in foyer. The resident stated "went outside for fresh air and the door locked on me". The resident was reminded not to go outside after midnight as the doors are locked.
- resident was observed at the front door punching in code to exit and stated " I am just going outside for some fresh air". The resident then went outside and was then observed walking through the parking lot towards the hill that leads to the road. The resident was redirected back to the unit at that time.
- resident was found in the front lobby (between the two front doors). The resident stated `just wanted to go outside for fresh air" but was unable to get back in due to doors being locked. The resident was returned to the unit.
- resident was found "at the front door a couple of times during the night attempting to enter the code to go outside"; the resident was found outside but was easily redirected back to the unit.

Interview of RN #137 had no knowledge of the resident's risk of responsive behaviours and indicated the resident always comes and goes from the home and goes out with another resident. Interview of RPN #120 indicated the resident was able to come and go from the facility independently and would check sign out book to determine if resident was in the home before becoming concerned with resident missing. Interview of PSW #138 was aware of incident, but indicated resident is now allowed to come and go from the home and indicated would notify nurse if unable to locate resident.

Review of the care plan (current and at time of incident) had no indication the resident was at risk due to specific responsive behaviours, no indication the resident frequently visiting another unit to visit another resident, or was able to leave the home independently and no interventions to manage these responsive behaviours. [s. 6. (1) (c)]

7. Related to Log # O-001388-14, for Resident #56:

The licensee failed to comply with LTCHA, 2007, s. 6 (7), by ensuring the care set out in the plan of care provided to the resident as specified in the plan, specific to Falls Prevention.

Resident #56 fell, on a specific date, sustained injuries as a result of the fall and was hospitalized. Resident returned to the home approximately two weeks later. The plan of care for Resident #56 was revised post-hospitalization indicating resident is at high risk

for falls.

The following observations were made on two separate occasions during this inspection:

- Resident #56 was observed lying in bed with the hi-low bed in a high position; bed was raised to the level of inspector's waist

Staff #122 indicated that Resident #56's bed was not required to be in the lowest position and that Resident #56 was not at risk for falls. Staff indicated Resident #56 may have elevated the bed his/herself as resident tends to play with the bed remote.

Staff #120 indicated that Resident #56 was at Falls Risk (high), noting the recent falls incident and decreased mobility. Staff #120 indicated that according to the written care plan, Resident #56's bed should be at all times in the lowest position in an effort to prevent further falls or injury.

A review of the written care plan indicated the following:
- requires total assistance of staff for all aspects of care
- has been assessed as HIGH Risk for Falls. The goal of care is identified as: risk of injury is minimized through to the next review period. Interventions, include: referral to physiotherapy, falling star logo is used to identify high risk, bed is to be kept in the lowest position, call bell and light cord is within reach, frequent reminders are needed to call for assistance.
- the plan of care lists the intervention 'keep bed in the lowest possible position'

The Director of Care indicated Resident #56 was at high risk for falls and the expectation is that staff are to follow the planned care in an effort to mitigate the risk of falls; DOC indicated that keeping the resident's bed in the lowest position was a planned strategy for Resident #56 in an effort to prevent falls. DOC was not aware of any issues pertaining to Resident #56 playing with the bed remote. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place to monitor that the plan of care provides clear directions to staff and others who provide direct care to the residents; and to ensure that the care set out in the plan of care provided to the resident as specified in the plan, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 17 (1) (b), by ensuring that the home is equipped with a resident-staff communication response system that is on at all times.

The following observation was made on December 16, 2014:

- the call bell was activated by Resident #04; it was noted that staff did not respond to the call bell for a period of over ten minutes
- the resident–staff communication and response system was not audible to staff in the corridor of the Corbett resident home area
- the call system, on Corbett (resident home area) sounded once at the time of activation only
- Staff #105 and 106, Personal Support Workers, working on the resident home area December 16, 2014 were not carrying pagers

PSW #105 indicated that the staff can see the light in the hall outside the resident's room and there is a monitor near the nurses station to see when and where a resident is ringing the call bell from. Staff #105 indicated that the Registered Practical Nurse, who is the Charge Nurse, usually gives the Personal Support Worker(s) a pager, but staff did not receive pagers that morning.

Staff #104, who is a Registered Practical Nurse, indicated that the PSWs, working on home area, were to carry a pagers with them while working; Staff #104 indicated not being able locate pagers to distribute to PSWs on the morning indicated above.

Executive Director and Director of Care indicated that the resident-staff communication and response system usually sounds to alert staff when a call for assistance is activated on the system. Both the Executive Director and Director of Care indicated that it is the homes expectation that Personal Support Workers, on Corbett home area, carry pagers at all times while working.

During an interview, the Environmental Supervisor indicated that a call that is activated on the system illuminates a dome light that is located in the corridor outside the calling location. The call also activates on an audio visual enunciation panel that is located in the corridor in the vicinity of the nurse's station. The Environmental Supervisor indicated the call system has not been set to alarm in the halls for the time that he has worked in the home.

The Executive Director indicated that the home does not have a call bell policy; she further indicated that it is the homes expectation for a staff member to respond to an activated call bell within five to ten minutes of the call bell being activated by the resident.

Executive Director and Director of Care informed inspector team on December 16, 2014

(30 min following the observation) that the pagers were located in the DOC's office as they needed batteries. Executive Director and DOC indicated that all staff on Corbett now have pagers and that pagers are now working properly.

The resident-staff communication and response system is an essential safety system to support the health, comfort, safety and well- being of residents. Pagers are an integral system component in the specific home area and not carrying the pager is a potential safety risk to residents in this home area. [s. 17. (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 to ensure there is a process in place and monitored to ensure that the resident-staff communication response system is on at all times and functioning properly, to be implemented voluntarily.

WN #5: 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. Related to Log #O-000864-14, for Resident #42:

The licensee has failed to comply with LTCHA, 2007, s. 24 (1), by ensuring that when they had reasonable grounds to suspect abuse of a resident by a staff member that resulted in harm or risk of harm occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Interview of the Executive Director and Director of Care, review of the homes investigational notes and review of the health records of Resident #42 indicated:
-on a specific date, resident was observed pushing Resident#63 forcefully in wheelchair. The resident's family was visiting and attempted to tell the Resident #42 to leave resident alone. Resident #64 also attempted to intervene and was punched. The resident's family then called for staff assistance. A staff member was witnessed using improper handling while attempting to manage the resident's responsive behaviour. A staff member reported rough handling of staff to resident between the nursing staff member and Resident #42. The staff member was placed on a leave pending the investigation and as a result of the investigation, the nursing staff member was disciplined for rough handling of Resident #42.

The Director of Care indicated the Director (MOH) was not notified of this incident. [s. 24. (1)]

2. Related to Log #O-001353-14, for Resident #50:

The licensee has failed to ensure that the Director was immediately notified when there were allegations of abuse between two residents that may have resulted in harm or risk of harm to the residents involved.

On a specific date, Resident # 48 was found inside Resident #50's room by a staff member rubbing Resident #50's lower extremity. Resident #48 was immediately removed from the area, assessed to have no injury. Resident #50 was assessed as well, no apparent distress. The DOC began their investigation the day in which the incident was said to have occurred. The Critical Incident was submitted to MOH two days later.

Prior to this incident, Resident #48 was involved in a different allegation of sexual abuse against Resident #45. Later (same day), Resident #48 was alleged to have another incident of sexual abuse involving Resident #51.

A critical incident report was submitted to the MOHLTC two days later.

The DOC indicated the following:
-The Director (MOH) was notified at time of submission of the critical incident report two days later. The DOC was aware that this did not meet legislative requirements of immediately reporting any suspected or witnessed allegations of sexual abuse. [s. 24. (1)]

3. Related to Log #O-001357-14, for Resident #51:

The licensee has failed to ensure that the Director was immediately notified when there were allegations of abuse between two residents that may have resulted in harm or risk of harm to the residents involved.

Resident #48 was witnessed approaching Resident #51 in the dining room and was observed by a non-registered staff member to be rubbing Resident #51's torso and kissing Resident #51. The non-registered staff member intervened and re-directed Resident #48. The non-registered staff member informed an RPN who according to a progress note entry informed both the DOC and the ADOC of this incident.

Prior to this incident, Resident #48 was involved in two different allegations of sexual abuse against Resident #50, and Resident #45.

A critical incident report was submitted to the MOHLTC two days following the incident.

The DOC indicated the following:
-The Director was notified two days following the incident. The DOC was aware that this did not meet legislative requirements of immediately reporting any suspected or witnessed allegations of sexual abuse. [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 there is a process and policy in place, monitored and complied with to ensure that the Director is immediately notified of any alleged, suspected or witnessed incidents of abuse, to be implemented voluntarily.

WN #6: 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:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

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. For Resident #18 and #25:

The licensee failed to comply with LTCHA, 2007, s. 31 (2) 4., by ensuring the restraint plan of care includes an order by the physician or the registered nurse in the extended class.

Resident #18 and #25 were observed in bed with ¾ bed rails (x2) in place and elevated throughout the day during a three day review period.

Staff #110 and #120 both indicated ¾ bed rails were considered restraints for both Resident #18 and #25.

The home's policy, Least Restraint (LTC-K-10) directs that an order indicating type of restraint, reason for restraint, and duration of continued use will be obtained prior to initial application of the restraint. The policy further directs that the ongoing use of the restraint (s) will be reviewed at least quarterly by the interdisciplinary team.

A review of the both resident's plan of care failed to provide documentation of any order (s) for the use of ¾ bed rails, as a restraint, by the physician (or a registered nurse in the extended class) for Resident #18 and #25.

The Director of Care indicated that restraints, which included the use of ¾ bed rails, were required to be approved and ordered by the resident's physician. [s. 31. (2) 4.]

2. For Resident #18 and #25:

The licensee failed to comply with LTCHA, 2007, s. 31 (2) 5., by ensuring the restraint plan of care includes the consent by the resident or if the resident is incapable, by the Substitute Decision Maker.

Resident #18 and #25 were observed in bed with ¾ bed rails (x2) in place and elevated throughout the day, during a three day observation period; staff indicated the use of ¾ bed rails were considered a restraint for the two resident's.

A review of Resident #18 and #25's plan of care failed to provide any supporting documentation that SDM's were consulted or consented to the use of ¾ bed rails as a restraint for Resident #18 and or #25.

Staff #120 indicated that neither Resident #18 nor #25 were able to consent to the use of bed rails due to impaired cognition. Staff #120 indicated that there were no consents on file for use of bed rails, as a restraint, for Resident #18 nor #25.

The home's policy, Least Restraints (LTC-K-10) directs that the Resident / SDM consent for the initial application of the restraint and the consent will be reviewed annually or if there is a change in the type of restraint.

The Director of Care indicated that all restraints must be consented to by either the Resident or SDM. DOC indicated awareness that consents for use of restraints (e.g. ¾ bed rails) were not present for the majority of residents using bed rails as restraints. [s.

31. (2) 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 there is a process in place, monitored and complied with to ensure the restraint plan of care includes an order for restraint use and consent by resident, or if the resident is incapable, by the Substitute Decision Maker, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD 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. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. For Resident #15:

The licensee failed to comply with LTCHA, 2007, s. 33 (3), by ensuring the PASD described in subsection (1) that is used to assist a resident with a routine activity of living is included in the residents' plan of care.

Note: Subsection (1) applies to the use of a PASD if the PASD has the effect of limiting or inhibiting a resident's freedom of movement and the resident is not able, either physically or cognitively, to release himself from the PASD .

The following observation was made during the day on three separate dates:
- Resident #15 was observed in bed with ½ bed rails (x2) elevated; bed rails were positioned mid bed.

Resident #15 indicated that bed rails assist him/her in turning in bed; resident indicated being unable to get out of bed independently.

Staff #110 indicated that bed rails were being used for bed mobility/positioning; staff indicated Resident #15 could not release bed rails independently and rely on staff to raise and release bed rails.

A review of the plan of care for Resident #15 failed to provide any documentation that bed rails were being utilized for Resident #15. Staff #120 reviewed Resident #15's plan of care and confirmed that use of bed rails was not identified in the plan of care.

Director of Care indicated awareness that bed rails as a Personal Assistive Services Devices (PASDs) were not consistently documented in the plan of care for residents within the home. [s. 33. (3)]

2. For Resident #15:

The licensee failed to comply with LTCHA, 2007, s. 33 (4) 3., by ensuring that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living included in a resident's plan of care only if the use of the Personal Assistance Services Device (PASD) has been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations.

Resident #15 was observed in bed throughout the day on three separate days; resident was observed with ½ bed rails (x2) elevated, bed rails were positioned mid bed.

A review of Resident #15's health record, including assessments, physician's orders, written care plan, and physiotherapy assessments failed to provide any supporting

documentation of bed rails being approved for use for this resident.

Staff #120 indicated that bed rails are normally elevated for all residents to prevent residents from falling out of bed; staff indicated such is a normal practice within the home. Staff #120 indicated that there was no approval for ½ bed rail use on file for Resident #15.

The home's policy, Side Rails (LTC-K-10-ON) directs that all residents using bed rails will be assessed for the need for side rails and the associated risk with utilization of side rails.

The Director of Care(DOC) indicated that bed rails for Resident #15 would be considered a PASD; DOC indicated that PASDs require a physician's order. [s. 33. (4) 3.]

3. Related to Resident #15:

The licensee failed to comply with LTCHA, 2007, s. 33 (4) 4., by ensuring the use of a Personal Assistive Services Device (PASD) under subsection (3) to assist a resident with a routine activity of daily living included in a resident's plan of care only if, the use of the PASD 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.

Resident #15 was observed, throughout the day on three separate days with ½ bed rails (x2) elevated and positioned mid bed. Resident indicated using bed rails for bed mobility and that staff elevate bed rails whenever he/she is in bed. Resident #15 indicated not being asked to have bed rails elevated, but that he/she was unable to get out of bed by self independently.

A review of the resident's health record failed to provide supporting documentation that ½ bed rails, considered a PASD by Staff #120, had been consented to by either the resident nor resident's SDM.

Director of Care indicated that PASDs required consent of resident if capable or SDM. [s. 33. (4) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place, monitored and complied with to ensure that PASDs used to assist a resident with a routine activity of living is included in the residents' plan of care, to be implemented voluntarily.

WN #8: 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):
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).

Findings/Faits saillants :

1. Related to Log #O-000864-14, for Resident #60:

The licensee has failed to ensure that the Director was immediately notified in as much detail as possible in the circumstances, of an incident in the home of a resident who was missing for more than three hours.

Review of the progress notes for Resident #60 indicated, on a specific date, the RPN noted the resident was not sitting at meal table but "thought the resident went to see a resident on another resident home area where he/she usually spends time". Forty minutes later, the RPN went to home area to locate the resident to give medications and was unable to locate the resident. The RPN then checked the resident's room and the resident was not located. The DOC was notified of the missing resident and directed the staff to continue attempting to call family. DOC called a code yellow when notified by family that resident was not with them. The Police and other managers were contacted. The police arrived at the home and description of resident provided. The resident was located by police and the resident was returned to the home without injury.

Review of the critical incident reporting system indicated no report of Resident #60 missing greater than three hours on the date identified.

The DOC confirmed that the police and POA were also contacted regarding the resident missing but did not notify the Director (MOH) because the resident was competent and able to come and go from the home. [s. 107. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place, monitored and complied with to ensure that the Director is immediately notified of incidents in the home when a resident is missing for more than three hours, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 3 (1) 11. iv, by ensuring that the resident's right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act has been fully respected and promoted.

The following observation was made on December 23, 2014, during the medication pass:
- medication strip pouches were observed being disposed of into a garbage bag located on the side of medication cart during medication pass observations on two separate resident home areas.

Interview with Staff #124, #121, #120, who are registered nursing staff responsible for administering medications from the said carts report that they dispose of all medication strip packs into the regular garbage which is emptied by the maintenance staff at the end of the shift into a central garbage bin. Staff #121 and #120 indicated that said medication strip pouches contain the residents' last name and medication which is considered personal health information. Staff #121 and #120 indicated that historically they had separated medication strip pouches from the regular garbage but had often found the shredder box to be full and unable to be used properly, hence the reason for change in their disposal practice.

Interview with Staff #104 and Staff #125, both registered nursing staff, report that medication strip pouches should be disposed of in a separate garbage bag which is then placed in a secured box for shredding by third party.

Assistant Director of Care (ADOC), indicated in an interview, that the medication strip pouches should be placed in separate garbage bag and then placed into a secured box for shredding by a third party. The ADOC reported that the medication strip pouches should not be placed in the regular garbage. [s. 3. (1) 11. i.]

WN #10: 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. Related to Log #O-000864-14, for Resident #60:

Under O.Reg. 79/10, s.230(4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with,
vii. situations involving a missing resident.

Review of the homes policy "Missing Resident" (EPM-F-10) indicated:
- In the event a Resident is suspected to be missing from a home the staff member will notify the person in charge immediately.
- The person in charge/designate will check the sign out book and health record to see if the Resident is signed our of the home.
- After a thorough check of the Resident Home Area, Registered staff will notify the Charge Nurse immediately of a suspected missing resident.
-The person in charge/designate will page three times "code yellow, name of resident, room number", followed by a brief description of what the resident was wearing.
- Registered staff will initiate "Missing Resident Search Checklist" to record the time, sequence and details of the search. The "Code Yellow Identify Chart" is completed and kept in the resident's chart when the resident is assessed as a high risk wanderer.
-Immediately on completion of the first search and before an exterior search is carried out, the Charge Nurse/designate will notify police. Staff will begin a second search and include delegating 2 staff to complete a check of the ground outside of the home.

Review of the progress notes for Resident #60 indicated that on a specific date, the RPN noted the resident was not sitting at meal table but "thought the resident went to see a resident on another resident home area where he/she usually spends time". Forty

minutes later, the RPN went to the resident home area to locate the resident to give medications and was unable to locate the resident. The RPN then checked the resident's room and the resident was not located. The DOC was notified of the missing resident and directed the staff to continue attempting to call family. DOC called a code yellow approximately two hours later, when notified by family that resident was not with them. The Police and other managers were contacted; the police arrived at the home and description of resident provided. The resident was located by police and the resident was returned to the home without injury.

The resident had been missing for a period of greater than three hours; there was a delay in initiating a code yellow and notifying police. A missing resident search checklist and code yellow identify chart was also not completed. [s. 8. (1) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 9 (1) 2., by ensuring that all doors leading to non-residential areas are to be locked when they are not being supervised by staff.

The following observations were made December 15, 2014:

- A housekeeping door in close proximity to the staff room and accessible to residents, was found unlocked; the room contained bottles of chemicals, which included: Diversity UC63 (3 bottles, as well as 2 cases 4x1.89L), Neutral Glass & Surface Cleaner (1), Diversity UC55 (1), Odour Neutralizer (2 cases of 4 x 1.89L), Swish Aromx 60 Super

Strength Foul Odour Eliminator (1), Vert 2 Go Odour Control (1), Diversity UC9 Non-Acid Bathroom Cleaner (1 bottle and 5 cases 4x 1.89L).

- A Sprinkler Valve Room across from the housekeeping door was also unlocked. This area has mechanical equipment including the shut off valve for the sprinkler system. The room also contained chemicals, which included: a 14 oz bottle of Nashua Tape Product spray adhesive 357 Premium Spray Adhesive.

The following observation was made on December 16, 2014:

- the housekeeping room on a specific resident home area was found unlocked; the room contained bottles of chemicals, which included: Bleach(1), UC9 Taski(1), Multi-Purpose Green(1), and a chemical dispensing machine with several lines of diluted R2a; the room contained three electrical panels.

Personal Support Worker #110 indicated the housekeeping room was to be locked at all times and further indicated that resident's with cognitive impairments and responsive behaviours (e.g. wandering or risk of inappropriate ingestion) resided on the resident home area.

Housekeeper (#109) indicated unlocking the housekeeping room on the date indicated above, so that Personal Support Workers could fill their R2a bottles. Staff #109 indicated that he/she routinely unlocks the door daily at a specific time and re-locks door at two and a half hours later to save time, thus not having to return when PSW's need access to the housekeeping room; Staff #109 indicated awareness that this practice was unsafe.

The home's policy, Housekeeping Services-Storage of Supplies (ESP-C-15), directs that housekeeping supplies are to be kept in a locked storage rooms which are inaccessible to residents and visitors.

Environmental Services Manager and the Executive Director both indicated that the expectation is that the housekeeping room(s) and sprinkler valve room are to be locked at all times when staff are not in attendance; Executive Director indicated that unlocked areas where chemicals are stored pose potential risk to residents, especially those with impaired cognition. [s. 9. (1) 2.]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2)(c), by ensuring the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following was observed during the dates of December 15 through to December 17, 2014:

Walls – scuffed (black marks), scratches and or walls chipped in room(s) - 13 resident rooms

Door Frames – scuffed (black marks), scratched and or chipped in room(s) - 10 resident rooms

Floors – flooring is visibly torn in room(s) - 3 resident rooms and in one resident home area Spa Room; concrete floor or sub-flooring is visible. (Note: torn or uneven flooring poses a trip hazard for residents)

Lounge - identified resident home area - screen door has a hole in it

Tub room - located on two resident home areas - cracked wall tiles

The Maintenance/Hazard Reporting book on one resident home area was reviewed for a three month period, work requisitions in this book failed to identify the above maintenance repairs required for areas located in the resident home area.

Environmental Service Manager indicated awareness of some of the above maintenance issues requiring repair, but confirmed that not all areas had been identified as requiring repair and or maintenance.

The Executive Director was in agreement that there are some areas of required maintenance repairs needed throughout the home areas. [s. 15. (2) (c)]

WN #13: 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. Related to Log #O-001357-14:

The licensee has failed to comply with LTCHA, 2007, s. 20 (1), by ensuring that the written policy that promotes zero tolerance of abuse and neglect of Residents is complied with.

Resident #48 was witnessed approaching Resident #51 in the dining room and was observed rubbing Resident #51's torso and kissing Resident #51. This was observed by a non-registered staff member who reported this to the RPN working. Progress notes, written by an RPN (on a specific date) indicated the ADOC and DOC were made aware of the incident involving Resident #48 and Resident #51.

The Director (MOH) was first made aware of this incident of abuse two days following the incident.

The home's policy, Resident Non-Abuse-Ontario (LP-C-20-ON) directs the following:
- Mandatory Reporting -Internal- Any staff member or person, who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a Resident must immediately report that suspicion and the information on which is it based to the Executive Director (ED) of the Home or, if unavailable, to the most senior Supervisor on shift at that time. The person reporting the suspected abuse or neglect must follow the Home's reporting requirements to ensure that the information is provided to the ED immediately.
- External-Mandatory reporting under the LTCHA (Ontario): Section 24(1) of the LTCHA requires a person to make an immediate report to the Director where there is a reasonable suspicion that certain incidents occurred or may occur. The LTCHA provides that any person who has reasonable grounds to suspect that any of the following has occurred, or may occur, must immediately report the suspicion and the information upon which is it based to the Director of the Ministry of Health and Long-Term Care (the

"Ministry").
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.

The home did not comply with the home's policy (LP-C-20-ON) by not immediately notifying the Director upon becoming aware of the incident of sexual abuse involving Resident #48 and Resident #51. [s. 20. (1)]

2. Related to Log # O-001353-14:

The licensee has failed to comply with LTCHA, 2007, s. 20 (1), by ensuring that the written policy that promotes zero tolerance of abuse and neglect of Residents is complied with.

Resident #48 was found inside Resident #50's room by a PSW staff member rubbing Resident #50's lower extremity. Resident #48 was immediately removed from the area, assessed to have no injury. Resident #50 was assessed as well, and found to be in no apparent distress. The DOC began their investigation into this matter the same day as the incident occurred.

The Director (MOH) was first notified of this incident two days following the incident occurring.

The licensee did not comply with home's policy (LP-C-20-ON) when they did not immediately notify the Director upon becoming aware of the incident of sexual abuse involving Resident #48 and Resident #50. [s. 20. (1)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 57 (2), by ensuring that when receiving advice related to concerns or recommendations from Residents' Council that there is a response in writing within 10 days.

In an interview with the Residents' Council executive members, Resident #52 and #53 indicated the following:

- The home has not been responding in writing within 10 business days to concerns brought forth by the Residents' Council. Rather, as indicated by Resident #52 and #53 the Executive Director will come into the Residents' rooms and speak to the residents individually after the meeting regarding the concern brought forth by the council.

A review of the Residents' Council minutes from meetings held during a two month period indicated the following:

- Concern was brought forth from a member of the Residents' Council committee that the ramp exiting the building to the area is too steep. The Residents' council liaison indicated that they would discuss this with the maintenance manager.

- The issue from the ramp that was raised during the RC meeting in previous month was addressed in this meeting indicating that the ramp needed to be maintained in this way due to directing water away from the building to prevent water from entering the building.

During an interview, Executive Director indicated that when they are invited to attend the Resident Council Meeting, they will respond to the concern immediately at the council meeting which often includes the discussions about the capital budget, funding processes and how funding is spent.

When asked about a concern raised during the period reviewed, specific to the ramp outside of the home, the Executive Director indicated that there was not a written response within 10 days, rather the issue was immediately rectified by the maintenance manager and was written into the following month's meeting minutes.
It is to be noted that the period reviewed, meetings took place greater than 10 days apart. When the Executive Director was asked if there was any documentation of the responses, from meetings, the ED indicated that they do not have any records separate from the minutes of the meetings. [s. 57. (2)]

WN #15: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received training annually related to the Resident's Bill of Rights, the policy related to zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and whistle-blowing protection.

Review of past year's training records show 100% of staff received training on Resident's Bill of Rights and 97% of staff received Resident Non-Abuse Program training. Review of current year's training records provided on December 31, 2014 show 98% of staff received training on Resident's Bill of Rights and 96% of staff received Resident Non-Abuse Program. The Staff Educator indicated that the staff who had not completed their required training were not on leave of absence but were actively working within the home throughout the current year.

Staff #131, who is the Education Coordinator, indicated that not all staff received training in Non-abuse and Bill of Rights in current year.

Director of Care indicated the expectation is for 100% of staff to have received annual re-training in Non-abuse and Resident's Bill of Rights. The DOC reported that not all staff received such training in the current year. [s. 76. (4)]

WN #16: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 229 (4), by ensuring that staff participate in the implementation of the infection prevention and control program.

The following was observed during the Resident Quality Inspection:
- Room #105 - an unlabelled hairbrush, in a shared resident washroom
- Room #106 - an unlabelled denture cup, in a shared resident washroom
- Room #109 - an unlabelled toothbrush and denture cup, in a shared
- Room #128 - two unlabelled toothbrushes in plastic cup, in a shared washroom
- Tub Room - two unlabelled specimen collection devices (hats) were located on the garbage can in this room; the devices contained dried yellow/brownish substance.
- Spa Room (#G27)- bedpans were seen on the floor, a dirty commode bucket was sitting on the toilet seat with used toilet paper inside the bucket, a supply cupboard with used creams and hair spray were seen inside the cupboard, all items were unlabelled.
- Shower Room (#G-80) - bottles of used lotion and deodorant were visible within the room; items were unlabelled.
- Spa Room (#2-23) - a hair brush containing hair, an opened bottle of antiperspirant, used toothpaste and toothbrushes were all visible within the room; all items were unlabelled.

The Director of Care indicated that it is the expectation that all resident care items are to be labelled for individual resident use. [s. 229. (4)]

During the inspection, while observing the lunch meal, taking place in a resident home area dining room, the following was observed:
- staff were seen taking tray service to residents remaining in their rooms; meals on the trays were seen not covered as they were taken through the dining room and down resident hallways
- during the same observation, a staff was observed carrying a tray with two glasses of water, and two glasses of milk, all items were uncovered; during another observation, the same staff member carried a tray with a bowl of soup uncovered to another area of the home

Observation on a separate date during the inspection:
- a Personal Support Worker was observed carrying a meal tray from the main dining room, down the hallway and into a room; the meal and beverages on the tray were uncovered. Note: Many of the resident's residing within the Resident Home Area were in isolation due to respiratory symptoms.

Staff #136, who is a dietary aide, indicated it is the homes expectation that the food trays are to be covered when they leave the dining room.

The Nutritional Care Manager indicated that the dietary staff had been recently provided education to ensure that the food and drinks on the trays are covered. Nutritional Care Manager indicated that past practice prior to the RQI starting was that plate covers were usually only utilized for tray service during outbreaks.

The Executive Director and the Director of Care (who is the Infection Control Lead) indicated it was the expectation that all meal trays are to be covered before leaving the dining room. [s. 229. (4)]

Issued on this 3rd day of February, 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) :	KELLY BURNS (554), GWEN COLES (555), KARYN WOOD (601), LYNDA BROWN (111), MARIA FRANCIS-ALLEN (552), MATTHEW STICCA (553)
Inspection No. / No de l'inspection :	2014_293554_0039
Log No. / Registre no:	O-001362-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 30, 2015
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	THORNTONVIEW 186 THORNTON ROAD SOUTH, OSHAWA, ON, L1J-5Y2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	HEATHER POWER

To REVERA LONG TERM CARE 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee is to prepare, submit and implement a corrective action plan to ensure safe transferring and positioning devices or techniques are being utilized when assisting residents.

This plan is to include who is to complete the task and by when:

1) Review and revise the plan of care for all current residents requiring the use of any mechanical lifting device (includes use of Alenti bath chair) to ensure there is clear direction to staff and others who provide direct care to residents; the care plan should include the type of assistance required, the type of mechanical lifting device required, and any safety devices or measures to be taken when utilizing the mechanical device.

2) Re-train all direct care staff on the home's policies specific to Safety in Ambulating, Lifting and Transferring.

3) Re-train all direct care staff on the homes safe lifts and transfers procedures to ensure all direct care staff are aware of requirements related to safe transfers and or lifts, and the use of mechanical lifting devices, which is to include safe use of the Alenti bath chair/lift.

4) To ensure there is a process in place to monitor that all direct care staff are following the home's SALT policies and that measures are in place and to be implemented should the policy not be followed.

This plan is to be submitted in writing to the attention of: LTC Homes Inspector Kelly Burns and emailed to kelly.burns@ontario.ca on or before February 13, 2015

Grounds / Motifs :

1. Related to Log #O-001388-14, for Resident #56:

The licensee failed to comply with O. Reg. 79/10, s. 36, by ensuring that staff use safe transferring and positioning devices or techniques when assisting residents.

The Director of Care submitted a Critical Incident Report(CIR), on a specific date, relating to an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the

resident's health status.

Details of the incident are as follows:
- Personal Support Worker (PSW) was providing care to Resident #56, while resident was seated on a mechanical lift. According to the CIR, PSW stated he/she was reaching for another mechanical lift, when Resident #56 leaned forward and fell to the floor.

According to the CIR details, no initial injury was noted by the registered nursing staff who assessed resident. Approximately two hours later, Resident #56 began complaining of discomfort; resident was transferred to hospital for assessment and was admitted due to injuries sustained, as a result of the fall.

Representatives from the home (Executive Director and Director of Care) initiated an investigation into the cause of why and how resident fell.

According to the home's investigation notes, Staff #122 had been in the room just prior to Resident #56 falling from the mechanical lift and indicated in his/her witness statement being aware that Staff #130 was not using the safety belt nor the safety arm (bar) while operating the mechanical lift; staff #122 further indicated that no second staff was present when he/she left the room.

Staff #122 indicated in his/her statement that it was 'common practice' for staff to remove the safety belt from the specific mechanical lift, while resident still on the lift, as the belt was cold for resident's when wet.

The Director of Care indicated that the investigation concluded that Staff #130 did not follow the home's Safe Lift and Transfer policies by failing to: a) not having two staff present during the operation of mechanical lift, b) not using safety belt on mechanical lift, and c) not having the safety arm/bar engaged when resident was on the mechanical lift.

Director of Care indicated Staff #130 was disciplined as a result of not following the home's Safe Lifting and Transferring policies. DOC indicated no discipline was issued to Staff #122, despite staff having knowledge of safety measures not in place prior to the incident occurring.

The home's policy, Bath Lifts, Tub Chairs and Shower Commodes (LTC-K-80) directs the following:

- Seatbelts/protective bar will be applied at all times while the Resident is sitting on the bath chair
- Two staff members will be present during the lifting and lowering of a Resident in a mechanical bathing device
- All equipment must be utilized in accordance with manufacturer's specifications

A poster posted on the spa room wall indicates the specific mechanical lift in use at the time of the incident requires the use of the safety belt and the safety bar to be in place while resident is on the mechanical lift.

The home's Safety in Ambulating, Lifting and Transferring Program Policy (HS16-P-10) directs that two staff will be present at all times while the mechanical device is in operation.

Staff #122 indicated, in an interview during the inspection, that if the safety belt, for the mechanical lift, is available then the safety belt would be used while bathing residents; staff did indicate that the safety belt is often missing and there is only one safety belt per spa room available. Staff indicated that the home has just ordered more safety belts following the incident involving Resident #56.

Staff #122 indicated that it's a common practice to remove the safety belt when resident is taken out of tub, but still sitting on the bath chair/lift as the wet, cold belt triggers responsive behaviours of some residents.

Staff #129 indicated that two staff are only present when a resident is transferred with mechanical lift from wheelchair to mechanical (bath) lift and from mechanical (bath) lift into wheelchair; staff indicated that there is only one staff member present when a resident is lifted out of the tub using the bath chair/lift and while resident is sitting on the mechanical (bath) lift being dried.

Director of Care indicated it is the expectation that the safety belt be used whenever a resident is on the specific mechanical (bath) lift, that the safety arm/bar be is to be in place when the lift is in use and that two staff are at all times to be present when the lift is operational. [s. 36.] (554)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 17, 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. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee is to prepare, submit and implement a corrective action plan to ensure residents are not neglected by the licensee or the staff. The licensee is to ensure that residents are provided with the treatment, care, services or assistance required for their health, safety and or well-being.

This plan is to include who is to complete the task and by when:

1) Review and revise the plan of care for all current residents requiring assistance with toileting to ensure there is clear direction to staff and other who provide direct care to residents which includes the type of assistance required, the number of staff required to complete task, and whether staff are to remain with the resident or whether the resident is able to call for assistance, and any other care required related to safe toileting.

2) Re-train all direct care staff on the home's policy of prevention of neglect of residents and what constitutes neglect.

3) Review and or revise the home's policy specific to shift to shift communications to ensure essential resident information (e.g. changes in plan of care, changes in resident health status, residents on leave of absence, residents needing assistance immediately following shift report, ect) is being captured in shift-shift report and communicated to essential nursing and support staff.

4) Re-train all direct care staff as to the process of shift to shift report, stressing the importance of communications as an essential component that ensures resident's safety, health and well-being.

This plan is to be submitted in writing to the attention of LTC Homes Inspector Kelly Burns and emailed to kelly.burns@ontario.ca on or before February 13, 2015.

Grounds / Motifs :

1. Related to Log #O-000737-14, for Resident #61:

The licensee failed to ensure that Resident #61 was not neglected by the licensee or staff.

Under the LTCHHA, 2007, s. 5. neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or

well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A critical incident report(CIR) was received on a specific date, for an incident of staff to resident neglect that occurred. The CIR indicated Resident #61 was placed on the toilet with a sit to stand transfer aide by staff; the report indicates staff did not inform the next shift. The resident was found on the toilet approximately 2 hours later. The resident was returned to bed and assessed; resident was noted to have altered skin integrity as a result.

Review of the care plan for Resident #61(in place prior to incident) related to toileting indicated the resident requires support to provide toileting as evidenced by inability to complete task safely and independently due to: impaired cognition and physical limitations. Interventions included: requires assistance with toileting tasks, use Sit to Stand transfer aid to transfer on/off toilet/commode.

Review of the homes policy "Safety In Ambulating Lifting and Transferring Program" (HS16-O-12) indicated on page 2 of 4 that two staff will always be present during the operation of the mechanical device, one staff acting as the leader and the other assisting with Resident/client safety.

Review of the resident's health record, the home's investigation, internal incident report, and interview of the DOC indicated the PSW assigned to Resident #61 on a specific date and shift was the staff member who transferred Resident #61 onto a toilet in the tub room with assistance of a co-worker. The resident was left on the toilet unattended, with the lift still attached, the door open, curtain pulled closed and the lights off. The DOC indicated the PSW left Resident #61 unattended on the toilet and did not report to oncoming shift. The PSW received disciplinary action as a result.

The licensee failed to ensure:
- the resident was not neglected by failing to ensure the written plan of care provided clear directions to staff as identified under WN #3 (for resident #61)
- staff failed to remain with the resident as per the home's policy
- staff failed to communicate to the oncoming shift that the resident was still on the toilet
- the oncoming shift failed to check on residents for approximately an hour
- the homes investigation only took actions towards the one staff who left the resident on the toilet but no actions were taken towards the oncoming shift [s.

19. (1)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 17, 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 30th day of January, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Burns

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