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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 1, 2014	2014_378116_0008	T-115-14	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

WESTSIDE
1145 Albion Road, Rexdale, ON, M9V-4J7

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

SARAN DANIEL-DODD (116), ARIEL JONES (566), ERIC TANG (529), JOANNE ZAHUR (589)

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): August 5, 6, 7,8, 11, 12, 13, 14,15,18, 19, 20, 21, 22, 25, 26, 2014.

The following log and inspection numbers were conducted in conjunction with this inspection: Log# T-408-13 (inspection# 2014_268529_0017), Log# T-295-14(inspection# 2014_340566_0010), Log# T-562-14(inspection #2014_157210_0014), T-811-14(inspection# 2014_353589_0010)and Log# T-910-14 (inspection# 2014_268529_0018.

During the course of the inspection, the inspector(s) spoke with the interim Executive Director, Director of Care (DOC), Assistant Directors of Care (ADOC), resident assessment instrument minimum data set (RAI-MDS)coordinator, environmental services manager, food service manager, registered dietitian, programs manager, recreational aides, office manager, registered staff members, personal support workers, cook, dietary aides, housekeeper, Family Council President, Resident's Council President, residents and family members.

During the course of the inspection, the inspector(s) conducted a tour of resident home areas, observed staff to resident interactions and provision of care, observed meal service, medication administration, reviewed relevant home records, relevant policy and procedures, training records, employee records and resident health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every residents' right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, is fully respected and promoted.

Resident #002 reported to the inspector, an incident where a personal support worker (PSW) was rude to the resident as the PSW referred to resident # 002 as a nuisance during toileting care. Record review and staff interviews confirmed that there were concerns reported to staff by the resident on two separate occasions, involving the PSW's approach to the resident during care, whereupon the resident's right to be treated with dignity and respect, and to participate in his/her care were not upheld.

An interview with the Director of Care (DOC) confirmed that the resident's rights were not respected, and the PSWs involved in both incidences had received counselling and discipline around respecting resident's rights. [s. 3. (1) 1.]

2. The following non-compliance is in relation to findings identified under T-408-13 (inspection # 2014_268529_0017) conducted in conjunction with this inspection (Log #T-115-14, inspection # 2014_378116_0008).

A review of the home's internal investigation file revealed that resident #025 had reported to the home on an identified date, that an identified registered staff member spoke rudely to the resident. An interview with resident #025 and the resident's power of attorney (POA) indicated that the identified registered staff member made resident #025 feel insignificant. Interviews with an ADOC and DOC confirmed that the identified staff member was disciplined. [s. 3. (1) 1.]

3. The licensee has failed to ensure that every resident's rights to be protected from abuse, is fully respected and promoted.

Record review revealed that resident #034, who is cognitively impaired and demonstrates wandering behaviours, was touched inappropriately by another resident on an identified date. An identified PSW confirmed witnessing the incident which occurred between resident #002 and #034. Staff interviews confirmed that resident #002 did not have a history of inappropriately touching other residents and that resident #034 did not sustain any injuries or ill effects from the incident.

Interviews with the ADOC and DOC revealed that there was a police investigation into

the incident and no charges were laid. An interview with the DOC confirmed that resident #034's right to be protected from abuse was not respected and promoted. [s. 3. (1) 2.]

4. Review of the clinical record for resident #013 revealed that the POA reported to the home that he/she was informed by the resident that he/she was hit in the face by a PSW.

Interview with an identified PSW indicated that on a specified date, while transferring resident #013 from one mode of transportation to another, the resident became restless and consequently hit the identified PSW in the upper leg. The PSW confirmed that he/she slapped the resident on his/her leg and told resident #013 that the police would be called if he/she tried to hit him/her again.

An interview with the DOC confirmed that the resident's right to be protected from abuse was not fully respected and promoted(210). [s. 3. (1) 2.]

5. The licensee has failed to ensure that every resident has the right to be protected by abuse.

A review of the home's investigation notes and interviews with complainant, ED, DOC and ADOC, confirms that alleged abuse captured on video tapes from the camera installed by the family of resident #045 was verified to have been actual incidents of emotional, verbal abuse and of neglect.

As a result, an identified PSW was terminated and an identified number of other PSW's received discipline resulting in unpaid suspensions.
The DOC confirmed that the resident's right to be protected from abuse was not respected and promoted. [s. 3. (1) 2.]

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. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

A review of resident #005's written plan of care indicates the presence of skin impairments to both heels which requires heel protectors to be worn at all times. Resident #005 was observed to be sitting in a wheelchair on an identified date, without the heel protectors.

Interviews with a registered staff and the DOC confirmed that the heel protectors are to be worn at all times as per the resident's written plan of care. [s. 6. (7)]

2. The following non compliance is in relation to findings identified under T-295-14 (inspection #2014_340566_0010), which was conducted in conjunction with this inspection.

Record review of resident #035's written plan of care indicates that the resident is at risk for falls and requires use of a bed and chair alarm for safety.

On identified dates, the resident was observed to be seated in a wheelchair without a functioning chair alarm in place.
Staff interviews confirmed that the resident is at high falls risk, has had multiple falls,

and requires use of both a bed and chair alarm at all times as a means of falls prevention.

An interview with the ADOC confirmed that resident #035 requires a chair alarm at all times when in a wheelchair, and that the intervention was not provided as set out in the plan of care. [s. 6. (7)]

3. The following non compliance is in relation to findings identified under T-1059-14 (inspection # 2014_340566_0013), which was conducted in conjunction with this inspection.

Record review of resident #037's written plan of care revealed that, a behavioural intervention has been in place for staff to check the resident's room for an identified substance every evening and report the findings to the registered staff. A review of resident #037's progress notes indicated that registered staff notice symptoms that indicated the resident had managed access to this substance in his/her room on several occasions. The resident's health care record failed to reveal evidence that resident #037's room was consistently searched for the identified substance since the intervention was implemented.

The registered nursing staff further confirmed that unit staff were not checking the resident's room for the identified substance every evening, and that care was not provided as per the written plan of care. [s. 6. (7)]

4. The licensee failed to ensure that staff who provide direct care to a resident are kept aware of the contents of the plan of care.

The written plan of care for resident #008 documents that the use of a foley catheter is required as an intervention to enhance wound healing. The physician's order indicates that the foley catheter is to be changed once a month and the catheter bag to be changed every week on a specified day.

Interviews with registered staff members provided conflicting information regarding catheter care. An identified registered staff indicated that the catheter bag is to be changed every two weeks and as needed whereas, another identified registered staff member indicated that the foley catheter is to be changed every 4-6 weeks. [s. 6. (8)]

5. The following non compliance is in relation to findings identified under T-1059-14

(inspection # 2014_340566_0013), which was conducted in conjunction with this inspection.

The licensee failed to ensure that the staff who provide direct care to resident #038 were kept aware of the contents of the resident's plan of care.

Record review of resident #038's progress notes revealed that the resident had exit-seeking behaviours:
- On a specified date, the resident was referred to BSO related to agitation and exit-seeking.
- On a specified date, the resident went to the main floor saying he/she wants to go out.
- On a specified date, the resident stated he/she wanted to go home and was seen walking with a backpack, and seemed confused and agitated.
- On a specified date, the resident was observed to unpack all his/her belongings, saying he/she was going to a club or going home.

Further review of the resident's health care record (Point of Care) indicated the resident required hourly wandering checks. However, review of the resident's written care plan failed to reveal a section for responsive behaviours related to exit-seeking or the need for wandering checks.

An interview with an identified PSW revealed an unawareness of the resident's exit-seeking behaviours or need for hourly monitoring. An interview with an identified member of the registered nursing staff indicated that the resident was on hourly monitoring checks related to falls prevention, not to the exit-seeking behaviour.

The ADOC confirmed that the resident is an exit-seeker and requires hourly checks for this behaviour. [s. 6. (8)]

6. The licensee has failed to ensure that the resident was reassessed, and the plan of care reviewed and at any other time when the resident's care needs changed or the care set out in the plan was no longer necessary.

Record review indicated that resident #009 required extensive assistance for feeding and could manage finger foods. Observations revealed that resident #009 requires total assistance with all meals.

An interview with a restorative care coordinator confirmed that the residents care needs changed within the past month and that resident #009 now requires total assistance with all meals and can no longer manage finger foods. [s. 6. (10) (b)]

7. Record review of the current written plan of care for resident #001 indicated that the resident prefers to be transferred to bed before dinner and to have dinner in bed.

Observations revealed that the resident consumed dinner in the dining room on an identified date. Interviews held with an identified registered staff member and a PSW confirmed that the resident eats dinner in the dining room every evening and the plan of care is not reflective of the resident's current care needs.

An interview with the programs manager confirmed that the written plan of care should have been revised when the residents care needs changed. [s. 6. (10) (b)]

8. Observations of resident #005 revealed that the resident had used one side rail for bed mobility. Interviews with a PSW and a registered staff member confirmed that resident #005 uses one side rail for turning and repositioning in bed.

A review of resident #005's current written plan of care identified that the plan did not include the use of a side rail for the resident. Interviews with a registered staff member and the DOC confirmed that resident #005's written plan of care was not revised to include the use of a side rail for bed mobility. [s. 6. (10) (b)]

9. The following non compliance is in relation to findings identified under T-1059-14 (inspection #2014_340566_0013), which was conducted in conjunction with this inspection.

Review of the clinical record for resident #037 indicated that the resident had an order by the physician for a specified amount of an identified substance daily, as needed (PRN).

An interview with the resident indicated that he/she needed to request the identified substance from registered staff however, this process made the resident feel like a child. An interview with a member of the registered nursing staff indicated that the resident had been coming to the nursing station to get the identified substance and was requesting more than prescribed, but the nurse would not give it to resident #037. Registered staff members noticed symptoms that indicated the resident had managed

access to this substance in his/her room.

Review of the electronic medication administration record (eMAR) confirmed the resident had not taken any of the identified substance over a three-month period. On a specified date, the physician discontinued the previous order for the identified substance and ordered a specified amount of resident #037's preferred identified substance.

Resident #037's identified substance order and consumption was not reassessed, and the plan of care was not
revised over an identified three-month period when the resident's care needs changed. [s. 6. (10) (c)] (210) [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care provides the following:

1. that the care set out in the plan of care is provided to the resident as specified in the plan,
2. staff who provide direct care to a resident are kept aware of the contents of the plan of care and,
3. the resident was reassessed, and the plan of care reviewed and was revised at any other time when the resident's care needs changed or the care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #3: 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 following policies were complied with:

The licensee's drug destruction and disposal for non-narcotic and non-controlled drugs policy and procedure (#LTC-G-215-ON revised on February 2012) has been reviewed.
The policy and procedure states that the nurse is to check for expired medications on a weekly basis.

A number of expired medications were observed in the government stock room.

Interviews with the ADOC and DOC confirmed that the home's policy and procedure was not complied with for the above mentioned medications. [s. 8. (1) (b)]

2. The licensee's policy entitled Management of Concerns/Complaints/Compliments (policy LP-B-10, revised October 2011), indicated that the individual who is first aware of a verbal concern will initiate a customer service response (CSR) form, and upon completion of an investigation of the concerns, a response will be provided to indicate what has been done to resolve the complaint.

An interview with resident #003 reported that his/her wallet containing a specified nominal amount of money went missing on an identified date. The wallet was found however, did not contain the specified nominal amount.

An interview with an identified registered staff member confirmed that a CSR form was not initiated once staff were made aware of resident #003's missing wallet. [s. 8. (1) (b)]

3. An interview with resident #002 revealed a gold coloured ring went missing and was

never found, and an update never provided to the resident. Record review revealed and staff interview confirmed that a CSR form was never completed for the missing gold coloured ring that the resident reported to staff on a specified date.

Interviews with the ADOC confirmed that the home's procedure for managing concerns/complaints related to missing personal property was not followed as per the home's policy. [s. 8. (1) (b)]

4. Resident #002 revealed that a PSW was rude to him/her during toileting approximately a year and a half ago. Record review revealed and staff interview confirmed that a CSR form was never completed for the complaint that the resident reported to staff on a specified date.

An interview with the DOC confirmed that the home's procedure for managing concerns/complaints related to resident concerns/complaints was not followed as per the home's policy. [s. 8. (1) (b)]

5. The licensee's policy entitled Food and Fluid Intake Monitoring (policy LTC-G-30, revised March 2014), indicated that all residents will be monitored by using the proper food and fluid intake tracking system to ensure their nutrition/hydration care needs are being met.

Record review revealed that identified staff were referring to an outdated resident fluid list. An interview with the registered dietitian (RD) confirmed that this list is part of the home's food and fluid intake tracking system.

An interview with the DOC confirmed that the fluid list should be updated monthly, and at any other time when there is a change to a resident's fluid requirement, and that the home's policy was not followed. [s. 8. (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 that where the home is required 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 is complied with related to the following areas:
1. Drug destruction and disposal for non-narcotic and non-controlled drugs policy and procedure (#LTC-G-215-ON revised on February 2012)
2. Management of Concerns/Complaints/Compliments (policy LP-B-10, revised October 2011) and,
3. Food and Fluid Intake Monitoring (policy LTC-G-30, revised March 2014), to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following damages were observed during the inspection in the following resident home areas:

- wall damages near the washroom door frame, chipped paint on the main entrance door and washroom sliding door in an identified resident room.

- damages to the baseboard panel in an identified resident room and wall damage in the washroom.

- damage to baseboard panel in the washroom, damage on the washroom sliding door frame, and wall damage near the night drawer in an identified resident room.

- a large hole in the ceiling in an identified home area.

- damage to the side wall moulding near the shower stall and the hand-washing sink, and one cracked tile near the tub in an identified communal tub room.

- wall damage near the washroom door frame and closet of an identified resident room.

- a broken metal piece near the soap dispenser, chipped paint on the door frame, and partial separation of the flooring in an identified communal tub room.

An interview with the environmental service manager (ESM) confirmed the aforementioned areas were in a state of disrepair. [s. 15. (2) (c)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

Call bells in three identified resident rooms and one resident washroom were observed to be inoperable throughout the inspection.

Interviews with registered staff members and the ADOC confirmed the aforementioned call bells were non-functional and needing repair. [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 that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours are developed to meet the needs of residents with responsive behaviours.

The written plan of care for resident #002 did not identify written strategies or interventions related to the resident's responsive behaviours around inappropriate touching of other residents.

Record review and staff interviews revealed that resident #002 was accused of inappropriately touching other co-residents on two separate occasions.
A review of the resident's written plan of care on an established date during the

inspection, identified that it did not contain a section related to behaviours or inappropriate touching of other co-residents, or the management of these behaviours, as described by staff.

An interview with an identified PSW indicated that the resident's whereabouts needs to be checked frequently for safety, but that responsive behaviours were not outlined on the resident's care plan kardex. An interview with a member of the registered staff confirmed that the resident's written plan of care did not address responsive behaviours related to inappropriate touching of residents until an identified date during the inspection.

An interview with the DOC confirmed that inappropriate touching is considered a responsive behaviour and should have been outlined in the resident's written plan of care following the initial incident. [s. 53. (1) 1.]

2. A review of resident #034's written plan of care identified that it did not contain a section related to wandering.

Record review and staff interviews revealed that resident #034 wears a wander guard, tends to wander into other residents rooms, and that wandering is not a new behaviour for this resident.

Further interviews with identified staff members revealed that resident #034 was on a established frequency of safety checks following an incident with a co-resident. An interview with a member of the registered staff confirmed that the resident's written plan of care did not address responsive behaviours related to wandering.

An interview with the DOC confirmed that wandering is considered a responsive behaviour and should have been outlined in the resident's written plan of care. [s. 53. (1) 1.]

3. The following non compliance is in relation to findings identified under T-1059-14 (inspection # 2014_340566_0013), which was conducted in conjunction with this inspection.

The licensee has failed to ensure that written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours are developed to meet the needs of residents with responsive behaviours.

Review of resident #037's progress notes revealed two occasions over the past year where the resident had experienced visual hallucinations. The resident was assessed by a psychogeriatric physician who suggested a change in medication and recommended further monitoring. The visual hallucinations continued and progressively worsened despite the medication change and physician assessment.

An interview with an identified PSW indicated that the resident had a history of hallucinations. An interview with an identified registered staff member indicated that he/she did not have any knowledge of resident #037 having a history of visual hallucinations. Further review of the resident's written plan of care failed to reveal a section on responsive behaviours related to hallucinations.

The licensee failed to ensure that resident #037's written plan of care identified and set out written strategies around the resident's hallucinations. [s. 53. (1) 1.] [s. 53. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for each resident demonstrating responsive behaviours that written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours are developed to meet the needs of residents with responsive behaviours, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug related supplies and is secure and locked.

On a specified date, over a twelve minute period, the inspector observed a medication cart stored by the nurses station on an identified unit to be unlocked and unattended. Residents, non- registered staff members and visitors to the unit were observed in close proximity to the medication cart.

Interviews held with the assigned registered staff member, DOC and the interim Executive Director confirmed that all areas where medications are stored are to be locked at all times when they are not supervised [s.129 (1)(a)(ii)]. [s. 129. (1) (a)]

2. The following items were observed to be stored in an identified medication cart during the inspection:
- one Government of Canada cheque
- one denture
- two pairs of eyeglasses
- two costume jewellery bracelets
- two watches
- three hearing aids
- multiple hospital cards

Interviews with an ADOC and the DOC confirmed that the identified items should not be stored in the medication cart [s.129(1)(a)(i)]. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug related supplies and is secure and locked, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On an identified date, the inspector observed prescribed medications and topical treatments in resident #011's room. Record review failed to reveal authorization by a physician to self administer medications. Interviews held with the assigned registered staff member, PSW, the DOC and the interim Executive Director confirmed that the storage of the indicated drugs and drug related items were not authorized by a physician or registered nurse in the extended class to be stored in resident #011's room or his/her person. [s. 131. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written record of the annual Infection Prevention and Control program evaluation kept that includes the date of the evaluation, the names of the persons who participated, a summary of the changes made, and the date those changes were implemented.

An interview with the DOC and the homes interim ED confirmed that an annual evaluation of the program was not conducted in 2013. [s. 229. (2) (e)]

2. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

Throughout the inspection, unlabelled personal care items were observed in identified shared resident washrooms.

Interviews with an identified registered staff member and the DOC confirmed that the identified personal care items should be labelled with the room number and residents name. [s. 229. (4)]

3. On a specified date, a resident fridge/freezer was observed to contain multiple unlabelled food and beverage items.

Staff interviews revealed that there was an unawareness as to who the unlabelled items belonged to, and that all food and beverages in common resident fridges should be labelled. An interview with the DOC confirmed that having unlabelled food and beverages in shared resident fridges is an infection control concern. [s. 229. (4)]

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

Three identified residents were not screened for tuberculosis within 14 days of admission.

The health records of the identified residents failed to confirm that they had been screened at some time in the 90 days prior to admission. Interviews held with the DOC and ADOC confirmed that these residents were not screened as required. [s. 229. (10) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the infection control program includes the following:

1. that staff participate in the implementation of the infection prevention and control program,
2. that each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee,
3. that there is a written record of the annual Infection Prevention and Control program evaluation kept that includes the date of the evaluation, the names of the persons who participated, a summary of the changes made, and the date those changes were implemented, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that planned menu items are offered and available at each meal.

The written plan of care for resident #006 and resident #012 documents these residents are on a specified diet.

A review of the lunch menu for the specified diet on an identified date, documents a identified first choice and identified alternate option.

During an observed lunch meal service, resident #012 was observed to refuse the first choice that was offered to him/her and not provided with the alternative option. An interview held with a dietary aide initially communicated that there was no other option for the specified diet available however, an alternate option different than what was documented on the planned lunch menu was later observed to be offered to the resident.

Interviews held with the food service manager (FSM) confirmed that the specified diet must provide two options for all meals in accordance with the planned menu. The FSM further confirmed that resident's who required the specified diet were not provided with the planned alternate option for lunch on the identified date. [s. 71. (4)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

An interview with the President of the Family Council and the DOC confirmed that the home did not seek their advice in the development and the carrying out of the satisfaction survey, and in acting on its results. [s. 85. (3)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Interviews with an ADOC and the DOC confirmed that the home's medication management system has not been evaluated on a quarterly basis. [s. 115. (1)]

Issued on this 14th day of November, 2014

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

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) :	SARAN DANIEL-DODD (116), ARIEL JONES (566), ERIC TANG (529), JOANNE ZAHUR (589)
Inspection No. / No de l'inspection :	2014_378116_0008
Log No. / Registre no:	T-115-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 1, 2014
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	WESTSIDE 1145 Albion Road, Rexdale, ON, M9V-4J7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lydia Baksh

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure that the following rights of residents are fully respected and promoted for residents #002, #013, #025 and #034 :
- Resident #013 and resident #034 shall be protected from abuse
- Resident's #002 and #025 shall be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

The licensee shall submit a compliance plan to: Saran.DanielDodd@ontario.ca no later than October 10, 2014.

Grounds / Motifs :

1. The following non-compliance is in relation to findings identified under T-408-13 (inspection # 2014_268529_0017) conducted in conjunction with this inspection (Log #T-115-14, inspection # 2014_378116_0008).

A review of the home's internal investigation file revealed that resident #025 had reported to the home on an identified date, that an identified registered staff member spoke rudely to the resident. An interview with resident #025 and the resident's power of attorney (POA) indicated that the identified registered staff member made resident #025 feel insignificant. Interviews with an ADOC and DOC confirmed that the identified staff member was disciplined. [s. 3. (1) 1.] (529)

2. The licensee has failed to ensure that every residents' right to be treated with

courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, is fully respected and promoted.

Resident #002 reported to the inspector, an incident where a personal support worker (PSW) was rude to the resident as the PSW referred to resident # 002 as a nuisance during toileting care. Record review and staff interviews confirmed that there were concerns reported to staff by the resident on two separate occasions, involving the PSW's approach to the resident during care, whereupon the resident's right to be treated with dignity and respect, and to participate in his/her care were not upheld.

An interview with the Director of Care (DOC) confirmed that the resident's rights were not respected, and the PSWs involved in both incidences had received counselling and discipline around respecting resident's rights. [s. 3. (1) 1.] (566)

3. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be protected from abuse.
The following non-compliance is in relation to finding identified under T-910-14 (inspection # 2014_268529_0018) conducted in conjunction with the present RQI.
A review of the home's internal investigation file and an interview with a private sitter revealed that s/he had witnessed an identified PSW hit resident #026 in the head using a plastic hair comb while the resident's hair was being combed. An interview with the DOC confirmed that staff are not expected to hit residents whatsoever. (529)

4. The licensee has failed to ensure that every resident has the right to be protected by abuse.

A review of the home's investigation notes and interviews with complainant, ED, DOC and ADOC, confirms that alleged abuse captured on video tapes from the camera installed by the family of resident #045 was verified to have been actual incidents of emotional, verbal abuse and of neglect.

As a result, an identified PSW was terminated and an identified number of other PSW's received discipline resulting in unpaid suspensions.

The DOC confirmed that the resident's right to be protected from abuse was not respected and promoted. [s. 3. (1) 2.]
(589)

5. Review of the clinical record for resident #013 revealed that the POA reported to the home that he/she was informed by the resident that he/she was hit in the face by a PSW.

Interview with an identified PSW indicated that on a specified date, while transferring resident #013 from one mode of transportation to another, the resident became restless and consequently hit the identified PSW in the upper leg. The PSW confirmed that he/she slapped the resident on his/her leg and told resident #013 that the police would be called if he/she tried to hit him/her again.

An interview with the DOC confirmed that the resident's right to be protected from abuse was not fully respected and promoted (210). [s. 3. (1) 2.]

(116)

6. The licensee has failed to ensure that every resident's rights to be protected from abuse, is fully respected and promoted.

Record review revealed that resident #034, who is cognitively impaired and demonstrates wandering behaviours, was touched inappropriately by another resident on an identified date. An identified PSW confirmed witnessing the incident which occurred between resident #002 and #034. Staff interviews confirmed that resident #002 did not have a history of inappropriately touching other residents and that resident #034 did not sustain any injuries or ill effects from the incident.

Interviews with the ADOC and DOC revealed that there was a police investigation into the incident and no charges were laid. An interview with the DOC confirmed that resident #034's right to be protected from abuse was not respected and promoted. [s. 3. (1) 2.]
(566)

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 : Oct 31, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 1st day of October, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SARAN Daniel-Dodd

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