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
May 7, 2014	2014_220111_0009	O-000280-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE WEXFORD RESIDENCE INC.
1860 Lawrence Avenue East, TORONTO, ON, M1R-5B1

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

THE WEXFORD
1860 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1R-5B1

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

LYNDA BROWN (111), KELLY BURNS (554), MATTHEW STICCA (553), SARAN DANIEL-DODD (116)

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): April 14-17, 22-23, 2014

A critical incident report (log #001157) was inspected currently during this inspection and had no areas of non-compliance.

During the course of the inspection, the inspector(s) spoke with the Executive Director(ED), Director of Care (DOC), Environmental Services Manager (ESM), the Program and Support Services Manager (PSSM), Dietary Manager, Registered Dietician (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, Families, Resident Council President, Family Council chairperson, housekeepers, and dietary aides.

During the course of the inspection, the inspector(s) toured the home, observed dining service, observed medication pass, reviewed resident health care records, reviewed resident council and family council meeting minutes, reviewed the homes policies on storage of vaccines, Medication Storage, immunizations of staff and residents, preventative maintenance,

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
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
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 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 :

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

On a specified date it was observed the following items were stored in medication carts:
- A gold ring stored in a urine specimen cup was found in the third floor medication cart.
- Resident # 7000 hearing aid and batteries, one pair of unlabeled eye glasses and one pair of earphones for Resident# 7002 in the fourth floor medication cart. [s. 129. (1) (a)]

2. The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

This area of non-compliance was previously issued on April 11, 2014.

On a specified date and time, the door to the medication room on the 3rd floor unit was observed to be left ajar. The medication cart was unlocked and the electronic medication record was visible with resident personal health information. Residents, PSW's and housekeeping staff were observed passing the room without the registered staff's knowledge. RPN #107(assigned to the medication cart) was observed inside of the nursing station conversing with RPN #128 and was not aware of the presence of the inspector on the unit.

Interview held with RPN #107 confirmed that the medication room and cart are to be locked when unattended but RPN #107 denied not being in attendance to the medication cart despite not being in the medication room (116).

On a specified date, a treatment room on the third floor was found unlocked with treatment cleansing products and treatment creams accessible(111).

On a specified date and time, a medication cart was observed on the 4th floor left unattended and unlocked. Staff #120 returned to the medication cart after 5 minutes (553).

3. On a specified date, a fridge in the nursing station on unit #5 was found containing 3 boxes of Prolia injections, 2 bottles of Calcium liquid, 3 boxes of Tylenol 650mg suppositories, 2 boxes of Glycerin suppositories, 5 boxes of Tubersol, 1 box of Pneuomvax and 2 boxes of Tetanus Diptheria vaccines. This fridge did not have a locking device and was located in a room that was accessible to non-registered nursing personnel. PSW's, RD, Programing Staff, External Contracted Services (Motion Specialties) and residents were all observed going in and out of this area.

Interview of RPN #105 indicated that the room and the fridge is never locked. The RPN indicated that the vaccines are normally stored on Unit #2 and that this fridge was normally used only for storage of specimens.

Nurse Manager #104 was notified of the area not being secured or locked and the following day, the fridge containing the medications remained unsecured and only the Tetanus Diptheria vaccines and Tubersol had been removed. The inspector notified the Executive Director and a lock was applied to the fridge.

On a specified date, the nursing station/medication room on unit #7 contained a fridge with 2 boxes of insulin, a box of Glycerin Suppositories and a box of Xalatan opthalmic solution. The room was accessible to interdisciplinary staff and residents.

Interview of RPN #114 indicated that the door to the nursing station/medication room is not normally closed but would be closed and locked effective immediately. The locking device used to lock the door was the same code used for all the utility, tub/shower room doors which all housekeeping and PSW's would have access to.

The DOC was notified of the concern and a lock was placed directly on the fridge the

same day.

4. The licensee failed to ensure that drugs are stored in an area or a medication cart that complies with manufacturer's instructions for the storage of the drugs.

The medication fridge on Unit #5 was observed to contain: 5 boxes of Tubersol, 2 boxes of Tetanus Diptheria vaccines and a box of Pneumovax vaccines.

Review of the Policy 'Storage of Vaccines' (#G-65) indicates vaccines are to be stored in a refrigerated area maintaining temperatures between 2-8 degrees Celsius. The documentation of temperatures is to be checked twice daily by the Charge Nurse on the day and evening shifts. If vaccines have been exposed to temperatures outside of the +2 to +8 degrees range that the local health unit is to be called immediately to find out if the home should return the vaccine or if the vaccine can still be used.

The temperature recording logs for the period of March 1 to April 15, 2014 were not consistently recorded and the temperature of the fridge on some of the dates were not between required range.
- March 1, 2, 19, 21, 22, 23, 25, 26, 27, 30, 31, 2014 had only AM only temperatures recorded. April 5, 8,2014 had only AM temperatures recorded, April 6th had only PM temperatures recorded and April 12 (PM) -15, 2014 had no temperatures recorded.
-April 1 (max temp 9.2), April 2 (max temp 9.6), April 3 (max temp 9.0), April 4 (max temp 9.1), April 12, 2014 (max 13.9/min 1.0/and current temp 11.9).

Interview of Nurse Manager(NM)#104 (assigned to unit #5)was notified of concerns regarding the fridge on unit #5 and was unaware why the vaccines were stored in a fridge with other medication, was not aware why the fridge was unlocked, and was not aware that temperatures were inconsistently recorded. The following day, the vaccines had been removed from the unit #5 fridge and a sign was posted indicating "no vaccine storage in this fridge". Nurse Manager #104 indicated that the vaccines were discarded.

Interview of the DOC indicated that the DOC was unsure as to why NM#104 threw out the vaccines and was unsure if the local health unit was notified.

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 :

The licensee failed to ensure that the plan of care was based on an assessment of the resident related to bowel management.

Review of plan of care for Resident #3638 indicated inaccurate assessment of the resident related to bowel management.

Interview with Staff #125 confirmed that assessment of Resident #3638 related to bowel management was inaccurate[s.6(2)].

2. The licensee failed to ensure the resident was provided care according to the plan related to eating.

On a specified date, approximately an hour past breakfast, Resident #3608 was observed left unattended in the room with a tray of food. The resident had only consumed a small portion of the breakfast.

Review of the care plan for Resident #3608 related to eating indicated the resident required supervision and prompting when eating and occasional assistance from staff.

Interview with Staff #111 indicated staff were to stay with the resident while eating.

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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that,
(a) there is an organized program of housekeeping for the home; 2007, c. 8, s. 15 (1).
(b) there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents; and 2007, c. 8, s. 15 (1).
(c) there is an organized program of maintenance services for the home. 2007, c. 8, s. 15 (1).

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 :

The licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

On April 14, 2014 the following was observed:
-3rd floor:a suction machine was stored on top of a stainless steel table that was soiled with a dried orange substance and crumbs.
-2nd floor:the grout in shower stall appears soiled with brown discoloring. [s. 15. (2) (a)]

2. On April 14, 2014 grout in shower stall on the second floor was observed to be unclean (#116).
-Floor surfaces throughout the tub/shower rooms on Units #2, 3, 4, 5, 6 and 7 were

observed visibly soiled; the flooring was black in colour along length of the tub and behind the door on Units #4, 5, and 7; the blackened areas could be scraped and soiling came off.
-The tiled floors surface in shower stalls located on Units #2, 3, 4, 5, 6, and 7 were visibly soiled and discoloured (yellow-brown); the soiled areas could be scraped off.
-Alenti bath chairs located in the tub/shower rooms on Units #3, 4 and 6 were observed to be in use and soiled with whitish film and or a shiny substance on the seat of the chair.
-Tubs located in Unit #3, 4, 5, 6 and 7 tub/shower rooms were observed to be soiled (fine blackish-grey particles and short black hair on tub edge and inside tub).
- Unit # 4 and 6 had dried black staining around the drain; soiling could be scraped off.

-The vinyl seating on the Unit #5 shower chair was soiled with a shiny substance.
-Shower/commode chairs located in tub/shower rooms on Unit # 3 and 4 had whitish film on the nylon backing of chairs.
-Grout and sealant at the base of the toilet in the tub/shower room on Unit #2, 3, 4 and 7 were discoloured / blackened and or soiled.
-The outer aspect of the toilet bowl and along the seat on Unit #2 and 3 were stained/ smeared with a yellow-brown substance.
-The mesh covers covering the clean linen carts on Units #2, 3, 4, 5, 6 and 7 were visibly soiled with a white substance.
-interview of PSW#133 and #134 indicated that the tub was to be cleaned before and after each resident bath, could not explain why the tub would be dirty and stated 'we have no baths on our shift'.
-DOC could not locate any policies/procedures related to tub cleaning by nursing staff.

-Interviews with HSK #123 and 124 indicated that the Housekeeping Staff were not responsible for the daily cleaning of tubs, shower chairs and or commodes. Staff #123 & #124 indicated only a deep clean of the tub/shower room floors and shower stall was completed monthly. HSK staff indicated there was no policy in place for 'how they were to deep clean' the tub/shower rooms there is currently no sign-off sheet for cleaning or deep cleans. The HSK staff indicated on April 22, 2014 the ESM had supplied housekeeping staff with a 'routine cleaning check sheet' for staff to use and would also be receiving a sign off sheet for deep-cleaning of tub/shower rooms.
-review of the housekeeping "job routine" indicates the tub/shower room is to be cleaned by housekeepers twice daily (between the hours of 0700–1400) but no indication as to how or what to clean in these rooms.

Interview of the Environmental Services Manager indicated they were a contracted serviced provider and had no awareness of Housekeeping Staff not cleaning bathtubs daily and indicated that the expectation was daily cleaning by housekeeping staff. ESM provided the inspector with a new policy 'Kohler L &D Tubs Cleaning Procedure', but indicated that housekeeping staff would be re-trained on the new policy April 23, 2014. Environmental Services Manager indicated 'there were no other housekeeping policies within the home'; ESM to contact Aramark, which is the company contracted to assist with policies for housekeeping services.

Wheelchair / Walker / Lift cleaning - Related to Residents #3513, 3551 and 3652:
-Wheelchairs or walkers belonging to Resident's #3513, 3515, 3551 and #3652 were observed soiled with food and debris.

Staff interviews with PSW #116 and RPN #114 indicated that the cleaning of wheelchairs, walkers and lifts were done by the night shift PSW's; both staff indicated no knowledge of the cleaning schedule.

Wheelchair / Walker / Lift Cleaning Schedule signage sheets could not be located. Nurse Manager #104 was able to locate the cleaning signage sheet for Unit #2 for April 2014; the sheet was blank.

The home's policy Equipment Cleaning / Repairs (#M-30) directs 'it is the responsibility of the PSWs on the night shift to clean all wheelchairs, g-chairs and walkers as per the cleaning schedule. The registered staff shall check all cleaned equipment to ensure done satisfactorily'.

Policy 'Equipment Care and Maintenance' (#F-60) indicates that a cleaning schedule for the cleaning of mobility aides and lifts will be located on each unit. Night PSWs are responsible for completing the cleaning and initialing the assignment book when completed. The Director of Care is responsible for ensuring the cleaning is carried out according to the schedule.

Director of Care indicated no awareness of the cleaning schedules for mobility aides and further indicated awareness of the deficiency. [s. 15.(2)(a)]

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

The following areas were identified:
- Unit #7 - tub/shower room – laminate finish surrounding the corner of sink vanity is chipped, and damaged, exposing jagged wood edges.
- Unit #7 – laminate finish covering a built in counter space/table across from the lounge is badly chipped in at least 3 areas; wooden surface is exposed.
- Unit #7 – laminate finish on an over bed table in a resident lounge is badly chipped, and damaged; sharp wooden splinters along edges of this table.
- Unit #5 – tub/shower room – wall guard is missing on the wall as you enter this room; edges are jagged and extremely sharp.
- Unit #3 – tub/shower room – laminate finish surrounding the corner of the sink vanity is chipped and damaged, exposing jagged wooden edges; the laminate finish is also chipped along the length of the vanity. Wooden wall guard running the length of the wall from shower to vanity is worn and requires sanding.
- Unit #2 - tub/shower room – laminate finish surrounding the corner of sink vanity is chipped, worn and/or damaged. Wooden wall guard running along wall adjacent to the shower stall is chipped, worn and has numerous areas which are covered with black, moist substance (query mildew)(554)

Environmental Services Manager indicated 'no awareness of the above issues'. Non intact surfaces cannot be effectively cleaned and sanitized or disinfected as needed presenting a potential infection prevention and control risk; jagged or non-intact surfaces pose an increased risk of skin tears to residents (554).

Floor coverings were damaged with surfaces not intact in a number of areas:
- Unit #7- tub/shower room – flooring in front of the shower is torn, area is approximately 40cm x 15cm; visible debris can be seen on the exposed sub flooring.
- Unit #2- tub/shower room – flooring in front of the shower stall and to the side wall beside the toilet is split, this area measures approximately two feet in length.
- Unit #5 – servery/alcove – flooring running the length of the wall is split and the metal threshold as you enter this area is lifting.
-the flooring as you enter rooms: #740, 623, 632 (washroom), 420, 421, 441, 443, room beside 443 (no number) 320, 321, 324, 327(bathroom) and 334 has been patched with duct tape which is peeling and soiled.
- the flooring is split ~ ¾ inch and is lifting as you enter the washroom in room #344; visible debris can be seen on the exposed sub flooring(554).

Environmental Services Manager indicated 'no awareness of the flooring issues'. Damaged flooring cannot be properly cleaned and presents a potential tripping hazard

when the surface is uneven(554).

Observation of mobility aides (e.g. wheelchairs)provided by the home:
-Resident #3515 was observed in a wheelchair which had badly cracked arm rests, the foam under the vinyl arm rests were exposed; the chair arms were being held together with scotch tape. Both tires on this chair were without tread.
-Resident #5558 was observed in a wheelchair which had cracked arm rests, the foam under the vinyl arm rests were exposed.

Personal Support Worker #116 indicated that all wheelchair / walker repairs are entered into the Motion Specialties binder.

A review of the Motion Specialties wheelchair/walker repair binder for the period of April 1-23, 2014 did not indicate Resident #3515 and #5558 as needing wheelchair repairs.

The Physiotherapist indicated that both chairs were on loan to the residents and were owned by The Wexford. PT was not aware of who was responsible for repairing them. PT was not aware of the chairs requiring repair.

The home's policy Equipment Cleaning and Repairs (#M-30) directs that 'equipment owned by the facility will be repaired by filling out a Maintenance Requisition on the PM Works' (now ISIS). A review of maintenance requisitions for the period of April 1-17, 2014, indicated no requisitions were issued for the wheelchairs(554).

-The tub on the 5th floor did not have the shower spray component connected to the water source rendering the tub not to be used.
-Resident #3575 call bell outlet at bedside and in the bathroom was hanging out from the wall rendering the call bell difficult to use. There was also a large area of wall damage to the outside wall of the bathroom.
-Resident #3641 wooden entrance door had several areas where the wood was chipped off the door and the bathroom vanity cabinet was missing a door knob with the sharp point of the screw still exposed and leaving sharp edges.
-Resident #3628 wooden entrance door had several areas of wood chipped of the door exposing jagged edges, several areas of wall damage at the bedside. The baseboard heater outlet cover was off exposing wires and laying on the floor beside a baseboard molding that was also laying on the floor beside the baseboard heater.
-Resident #3536 had wall damage beside the closet and a large piece of melamine

missing from the bathroom vanity exposing sharp edges beside the toilet(111).

The following area(s) were not maintained in a safe condition and in a good state of repair during the initial walk through of the home on April 14, 2014:
- The flooring (threshold) in front of entrance to resident room 441 has electrical tape on the floor
- floor entrance to communal washroom has a gap and there is not a smooth transition.
-3rd floor: had chips to paint on the wall under the handrail in the hallway from room 345 right up to the television mounted on the wall; wheelchair arms for Resident #5590 had several cracks to the material on both arms; storage of two wheelchairs in the hallway (one labelled for Resident #5592 and other on loan to Resident # 5591; entrance to communal washroom floor has a gap in the flooring.

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 kept clean and sanitary, and are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

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

On April 14, 2014 the Alenti tub lifts were observed in use in the tub rooms on the 2nd, 3rd, 4th and 6th floor, and did not have seat belts on or near each lift seat or available for use within the tub room. The tub room on 7th floor did not have a tub lift available for use.

The "Alenti Operating and Product Care Instructions" manual indicates:
- safety warnings that are prominently identified with symbols.
- page 3 of the instruction manual, the safety warning symbol description identifies that "Failure to understand and obey this warning may result in injury to you or to others".
- Safety instructions on page 4 of the manual identifies four safety warnings with symbols including "The safety belt must be used at all times to make sure the resident remains in an upright position in the middle of the seat."

2. Interview of RPN #106, and PSW #108 both indicated that a seat belt is not used on the Alenti bath chair/lift. Both staff indicated that they were not aware that a seat belt was to be used with this lifting device.

Interview of Nurse Manager #104 was not aware of the need for use of a seat belt with the Alenti bath chair/lift and did not know where to locate ARJO manufacture instructions for this device.

Interview of the DOC indicated on April 22, 2014 the seat belts for the Alenti bath chair had been ordered and received in the home but had not yet been installed.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

The licensee failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

On a specified date and time, the inspector observed two white pills stored in a medication cup in the discontinued bin of the third floor medication cart. The medication cup did not identify the medication and who it was prescribed for.

Interview of RN #100(administering the medications)identified the medication however, lacked the knowledge of the resident it was prescribed for. The RN indicated the resident refused the medications but the RN was going to reattempt again and should have put the pill back into the residents original package until administered or destroyed.

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 remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

2. Access to these areas shall be restricted to,

i. persons who may dispense, prescribe or administer drugs in the home, and

ii. the Administrator.

3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

The licensee failed to ensure all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

An interview held with the Administrative Assistant indicated they are responsible for ordering government stock medications and is provided access to the government stock medication room located on the second floor.The AA indicated they were not a nurse.

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 the security of the drug supply in the home includes access to these areas are restricted to persons who may dispense, prescribe or administer drugs in the home, to be implemented voluntarily.

WN #7: 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 :

The licensee failed to ensure that every resident's personal health information was kept confidential.

On a specified date during the lunch meal in the Main Dining Room, the following observation was noted:
-a "Small portion list" was posed under the clock and accessible to all visitors and staff which indicated the resident names, room numbers and that they were to receive small portions at meals.
- a "New admission list" was posted with resident names, table locations and diet that are prescribed. This list is located on the same wall as the small portion list. This list was removed after a staff member observed the inspector reviewing the list.

Interview with Food Service Manager (FSM) indicated the purpose of the small portion list was started because audits of the dining service noted that the residents on the "small portion list" were not receiving the proper portion sizes. The FSM indicated the list had to be outside of the kitchen because the staffs who are ordering the food need to be reminded of whether or not the resident is to receive the small portion serving.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee failed to ensure that the home is a safe and secure environment.

On a specified date and time, a housekeeping cart was observed to be left outside of a resident room. The cart was unlocked and unattended and contained the following chemicals: two bottles of virox, windex and other cleaning chemicals. The housekeeper assigned to the cart was observed to be on the other side of the unit in the laundry room. An interview held with the housekeeper confirmed that the carts should be locked at all times when not in use.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids labelled.

The following was observed in 5 different resident washrooms:
-a white brush, toothbrush and stick deodorant were not labelled for individual use and stored in the washroom; this is a shared resident washroom
-two toothbrushes, a razor, a brush, a urinal and a bar of soap were all unlabelled or not in a labelled container in the washroom; this is a shared resident washroom
-a white brush on counter, two toothbrushes, a k-basin, a bar of soap and a denture cup were all unlabeled or not in a labeled container for individual use and in the washroom; this is a shared resident washroom
-a brush, two toothbrushes, a k-basin, bar of soap and denture cup were all unlabelled or in a unlabelled container in the washroom; this washroom is a shared washroom with the adjoining resident room
-a toothbrush and a bottle of roll on deodorant were unlabelled and in the washroom; this is a washroom shared with the adjoining resident room.

2. The following was observed in the tub room on 2nd floor:
-2 bottles of shampoo provided by the residents and not labelled
-1 bottle of body lotion provided by the resident and not labelled
-1 urine hat sitting on a commode chair not labelled.

The following was observed in the tub room on 3rd floor:
-2 urine hats sitting on the floor and not labelled.
-6 bottles of body lotion provided by the resident and not labelled.
-1 bottle of hair spray provided by the resident and not labelled.

On a specified date it was observed in a shared washroom on the 3rd floor had a denture cup and toothbrush not labelled.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that as part of the organized program of maintenance services, that there are schedules and procedures in place for routine, preventative and remedial maintenance.

Interview of the Environmental Services Manager(ESM) indicated they are a contracted service provider by Aramark and works Monday to Friday 7-3. The ESM indicated the home also has maintenance/janitor services that work 7 days/week 24 hrs/day. The ESM indicated that general and preventative maintenance for fire, electrical, HVAC/water, and elevator systems are all additional contracted services. The ESM indicated that there were no schedules or policies in place for routine, preventative and remedial maintenance related to general maintenance of the home but this was completed via "work orders". The ESM indicated the home uses "ISIS electronic reporting system". The ESM indicated each nursing station has this loaded on their computers and the nursing staff are to responsible for identifying any maintenance concerns and then creating a work order via ISIS. The ESM indicated the maintenance/janitor staff will then retrieve and complete the work orders on a daily basis. The ESM indicated there is no daily, weekly or monthly audits currently completed in the home.

Review of the ISIS work orders for a 3 month period indicated the areas identified requiring maintenance were not noted and only the floors identified in the 7th floor tub room and nursing station were identified (as a result of the inspection).

Review of the "Preventative Maintenance" from Aramark did not indicate the use of ISIS or work orders and had no schedules or procedures in place.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that the written policies and protocols regarding the medication management system are approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director.

Review of the written policies and protocols and interviews held with the Administrator and Director of Care, indicated the written policies were not approved by the Director of Care, pharmacy service provider and the Medical Director.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (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, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually 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. 116 (1).

s. 116. (3) The annual evaluation of the medication management system must,
(a) include a review of the quarterly evaluations in the previous year as referred to in section 115; O. Reg. 79/10, s. 116 (3).
(b) be undertaken using an assessment instrument designed specifically for this purpose; and O. Reg. 79/10, s. 116 (3).
(c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 116 (3).

Findings/Faits saillants :

The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Interview of the Executive Director (Administrator) confirmed that the ED was not present during the September 24, 2013 annual evaluation of the medication management system.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 123. Emergency drug supply

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

Findings/Faits saillants :

The licensee failed to ensure that, at least annually, there is an evaluation done by the Medical Director, pharmacy service provider, Director of Care and Administrator, of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs.

The pharmacy service provider is responsible for conducting audits of the emergency drug box on an annual basis but there was no evidence that an audit was conducted in 2012 or 2013.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of the Physician orders for Resident #5590 indicated the resident was to receive two different narcotic analgesics at different times.

Review of the electronic Medication Administration Record (eMAR) for Resident #5590 indicated on a specified date and time, the resident did not receive the narcotic analgesics as ordered.

Interview of Staff #130 confirmed the wrong dose of narcotic analgesic must have been given on the specified date as the narcotic count was inaccurate following the narcotic administration for Resident #5590.

WN #15: 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. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
2. Residents must be offered immunization against influenza at the appropriate time each year. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

The licensee failed to ensure that the designated staff member to co-ordinate the program of infection prevention and control has education and experience in infection prevention and control practices.

Interview of the DOC indicated RN #104 was the designated Infection Control Nurse (ICN). Interview of the ICN confirmed they had no formalized training as an ICN and could not provide any proof of training in Infection Prevention and Control practices and confirmed no training certificates were provided to the employer upon hire.

2. The licensee failed to ensure that each resident admitted to the home is screened for tuberculosis(TB) within 14 days of admission unless the resident has already been screened at some time in the 90 day prior to admission.

Interview of the DOC indicated that the home is currently using the 2-Step TB screening process.

Review of the health care records of residents indicated:
-Resident # 5573 did not have the TB 2 step screening completed until 3 weeks after admission.
-Resident #5571 had no documented record of TB screening.
-Resident #5574 did not have TB 2 step screening completed until 4 months after admission and the results were still pending.
-Resident #5575 had TB screening Step 2 not completed until a year after admission.
-Resident #5572 did not have TB 2 Step screening completed until six months after admission.

3. The licensee failed to ensure that residents are offered immunizations against influenza at the appropriate time each year.

Review of the health records of residents indicated:
-Resident #5572 had no evidence of influenza offered.
-Resident #5573 indicated was still waiting consent for Influenza.
-Resident #5571 had no indication of influenza offered.
-Resident #5574 had no documented evidence that influenza was offered.

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

Issued on this 7th day of May, 2014

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

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111), KELLY BURNS (554), MATTHEW STICCA (553), SARAN DANIEL-DODD (116)
Inspection No. / No de l'inspection :	2014_220111_0009
Log No. / Registre no:	O-000280-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 7, 2014
Licensee / Titulaire de permis :	THE WEXFORD RESIDENCE INC. 1860 Lawrence Avenue East, TORONTO, ON, M1R-5B1
LTC Home / Foyer de SLD :	THE WEXFORD 1860 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1R-5B1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SANDY BASSETT

To THE WEXFORD RESIDENCE 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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(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).

Order / Ordre :

1)The licensee shall ensure that all medication carts in use are used exclusively for drugs or drug-related supplies only.

2)The licensee shall ensure that all medication rooms, treatment rooms, medication carts, and fridges containing drugs are secured and locked.

3) The licensee shall ensure that all areas where medications are stored and locked, are accessible only to those able to prescribe, dispense or administer medications.

4) The licensee shall ensure that vaccines are stored in a separate refrigerator which is locked and in a secured area and to ensure that fridge temperature is monitored to ensure vaccines are kept within the Public Health Unit or manufacturers guidelines.

5) The licensee shall create and implement an process to monitor compliance with respect to safe and secure storage of medications and compliance with regards to safe storage of vaccines and temperature monitoring.

6)The licensee shall re-train registered staff on safe storage of medications, vaccine storage and monitoring.

Grounds / Motifs :

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

On a specified date it was observed the following items were stored in medication carts:
- A gold ring stored in a urine specimen cup was found in the third floor medication cart.
- Resident # 7000 hearing aid and batteries, one pair of unlabeled eye glasses and one pair of earphones for Resident# 7002 in the fourth floor medication cart. (116)

2. 2. The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

This area of non-compliance was previously issued on April 11, 2014.

On a specified date and time, the door to the medication room on the 3rd floor unit was observed to be left ajar. The medication cart was unlocked and the electronic medication record was visible with resident personal health information. Residents, PSW's and housekeeping staff were observed passing the room without the registered staff's knowledge. RPN #107(assigned to the medication cart) was observed inside of the nursing station conversing with RPN #128 and was not aware of the presence of the inspector on the unit.

Interview held with RPN #107 confirmed that the medication room and cart are to be locked when unattended but RPN #107 denied not being in attendance to the medication cart despite not being in the medication room (116).

On a specified date, a treatment room on the third floor was found unlocked with treatment cleansing products and treatment creams accessible(111).

On a specified date and time, a medication cart was observed on the 4th floor left unattended and unlocked. Staff #120 returned to the medication cart after 5 minutes (553). (116)

3. 3. On a specified date, a fridge in the nursing station on unit #5 was found containing 3 boxes of Prolia injections, 2 bottles of Calcium liquid, 3 boxes of Tylenol 650mg suppositories, 2 boxes of Glycerin suppositories, 5 boxes of Tubersol, 1 box of Pneuomvax and 2 boxes of Tetanus Diptheria vaccines. This fridge did not have a locking device and was located in a room that was accessible to non-registered nursing personnel. PSW's, RD, Programing Staff, External Contracted Services (Motion Specialties) and residents were all observed going in and out of this area.

Interview of RPN #105 indicated that the room and the fridge is never locked. The RPN indicated that the vaccines are normally stored on Unit #2 and that this fridge was normally used only for storage of specimens.

Nurse Manager #104 was notified of the area not being secured or locked and the following day, the fridge containing the medications remained unsecured and only the Tetanus Diptheria vaccines and Tubersol had been removed. The inspector notified the Executive Director and a lock was applied to the fridge.

On a specified date, the nursing station/medication room on unit #7 contained a fridge with 2 boxes of insulin, a box of Glycerin Suppositories and a box of

Xalatan opthalmic solution. The room was accessible to interdisciplinary staff and residents.

Interview of RPN #114 indicated that the door to the nursing station/medication room is not normally closed but would be closed and locked effective immediately. The locking device used to lock the door was the same code used for all the utility, tub/shower room doors which all housekeeping and PSW's would have access to.

The DOC was notified of the concern and a lock was placed directly on the fridge the same day. (554)

4. 4. The licensee failed to ensure that drugs are stored in an area or a medication cart that complies with manufacturer's instructions for the storage of the drugs.

The medication fridge on Unit #5 was observed to contain: 5 boxes of Tubersol, 2 boxes of Tetanus Diptheria vaccines and a box of Pneumovax vaccines.

Review of the Policy 'Storage of Vaccines' (#G-65) indicates vaccines are to be stored in a refrigerated area maintaining temperatures between 2-8 degrees Celsius. The documentation of temperatures is to be checked twice daily by the Charge Nurse on the day and evening shifts. If vaccines have been exposed to temperatures outside of the +2 to +8 degrees range that the local health unit is to be called immediately to find out if the home should return the vaccine or if the vaccine can still be used.

The temperature recording logs for the period of March 1 to April 15, 2014 were not consistently recorded and the temperature of the fridge on some of the dates were not between required range.
- March 1, 2, 19, 21, 22, 23, 25, 26, 27, 30, 31, 2014 had only AM only temperatures recorded. April 5, 8,2014 had only AM temperatures recorded, April 6th had only PM temperatures recorded and April 12 (PM) -15, 2014 had no temperatures recorded.
-April 1 (max temp 9.2), April 2 (max temp 9.6), April 3 (max temp 9.0), April 4 (max temp 9.1), April 12, 2014 (max 13.9/min 1.0/and current temp 11.9).

Interview of Nurse Manager(NM)#104 (assigned to unit #5)was notified of concerns regarding the fridge on unit #5 and was unaware why the vaccines

were stored in a fridge with other medication, was not aware why the fridge was unlocked, and was not aware that temperatures were inconsistently recorded. The following day, the vaccines had been removed from the unit #5 fridge and a sign was posted indicating "no vaccine storage in this fridge". Nurse Manager #104 indicated that the vaccines were discarded.

Interview of the DOC indicated that the DOC was unsure as to why NM#104 threw out the vaccines and was unsure if the local health unit was notified. (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 2014

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that all residents requiring supervision and/or assistance on tray service receive the assistance as indicated in the plan of care.

Grounds / Motifs :

1. The licensee failed to ensure the resident was provided care according to the plan related to eating.

On a specified date, approximately an hour past breakfast, Resident #3608 was observed left unattended in the room with a tray of food. The resident had only consumed a small portion of the breakfast.

Review of the care plan for Resident #3608 related to eating indicated the resident required supervision and prompting when eating and occasional assistance from staff.

Interview with Staff #111 indicated staff were to stay with the resident while eating. (553)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 09, 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.

Ministry of Health and Long-Term Care	Ministére de la Santé et des Soins de longue durée
Order(s) of the Inspector	**Ordre(s) de l'inspecteur**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8	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

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 7th day of May, 2014

Signature of Inspector / Signature de l'inspecteur : L Brown

Name of Inspector / Nom de l'inspecteur : LYNDA BROWN

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