Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 15, Feb 26, 2015	2015_282543_0001	T-000116-14	Resident Quality Inspection

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

WHITE EAGLE RESIDENCE
138 DOWLING AVENUE TORONTO ON M6K 3A6

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

TIFFANY BOUCHER (543), FRANCA MCMILLAN (544), JENNIFER LAURICELLA (542)

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): January 6-16, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, Registered Staff (RNs and RPNs), RAI/MDS Coordinator, Personal Support Workers (PSW), Food Service Manager, Maintenance Coordinator, Program and Support Services Manager, Project Manager, Housekeeping Staff, Residents and Family Members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Recreation and Social Activities
Residents' Council
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
13 WN(s)
3 VPC(s)
4 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 17. (1)	CO #901	2015_282543_0001	543
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #902	2015_282543_0001	543

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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. On January 14, 2015 Inspector #542 and #543 were on a resident care area. Inspector #542 proceeded to resident #040's room and found resident lying in bed. The resident asked inspector #542 if there was a nurse available, and the Inspector advised the resident to pull their call bell. Resident #040 attempted to pull their call bell cord however it was caught on the drawer of the bedside table and they were unable to engage the call bell system. At 5:06pm, inspector #542 assisted this resident with engaging their call bell. Staff #101 informed the Inspector that the call bell system was not working correctly. Inspector #542 then proceeded to the main floor and noted that there was a call light on in the hallway however there was no sound coming from the unit, therefore the staff did not know that a resident was calling. The call light also did not indicate which resident required assistance nor did it identify a resident care area. The Administrator informed the inspectors that the staff have to go to each unit in order to identify which resident is calling for help.

On January 15th, 2015, inspector #542 observed resident #040 sitting in their wheelchair in their room and this resident did not have access to their call bell. The resident asked

the inspector to pass them the call bell, inspector #542 asked staff #100 to come to resident #040's room and showed them that this resident did not have immediate access to their call bell. Staff #100 proceeded to clip the call bell to this resident's shirt.

The licensee failed to ensure that the home's resident-staff communication and response system can be easily accessed and used by residents at all times. [s. 17. (1) (a)]

2. On January 14, 2015 inspector #542 and #543 were on a resident care area. Inspector #542 proceeded to Resident #040's room, the resident asked the inspector if there was a nurse available. The inspector advised the resident to pull their call bell. Inspector #542 proceeded to the main floor where staff and residents where gathered in the dining room for the supper meal, while inspector #543 stayed on the unit. The inspector noted that the call light was lit up in the hallway however no sound was coming from the unit, therefore the staff did not know that a resident was calling for assistance. The call light also did not indicate which resident required assistance nor did it identify the resident care area. The Administrator informed the inspectors that the staff has to go to each unit in order to identify which resident is calling for help.

The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that, clearly indicates when activated where the signal is coming from. [s. 17. (1) (f)]

3. On January 14, 2015 Inspector #542 and #543 were on the 4th floor resident care area. Inspector #542 proceeded to resident #040's room and found resident lying in bed. The resident asked inspector #542 if there was a nurse available, the inspector advised the resident to pull their call bell. Resident #040 attempted to pull their call bell cord however it was caught on the drawer of their bedside table and they were unable to engage the call bell system. At 5:06pm, Inspector #542 assisted this resident with engaging their call bell. Registered Staff #101 informed this Inspector that the call bell system was not working correctly. Inspector #542 then proceeded to the main floor and noted that there was a call light on in the hallway however there was no sound coming from the unit, therefore the staff did not know that a resident was calling. The call light also did not indicate which resident required assistance nor did it identify a resident care area. The Administrator informed the inspectors that the staff have to go to each unit in order to identify which resident is calling for help.

The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that, 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. [s. 17. (1) (g)]

Additional Required Actions:

CO # - 901 was served on the licensee. CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. On January 14, 2015 Inspector #542 and #543 were on a resident care area and noted that two residents were in bed. Both inspectors noted that there were no staff members present on this unit at that time; to monitor or provide care to these two residents. Resident #040 asked inspector #542 if there was a nurse available, the inspector informed the resident that there was no nurse on the unit and that he should pull the call bell. Resident #040 attempted to pull his call bell however he was unable to do so as the pull cord was stuck in a drawer of his bed side table. Inspector #542 assisted the resident with pulling his call bell at 5:06pm. Both inspectors waited on the unit for 20 minutes and observed that no staff members were coming to the unit to answer the resident's call bell. Inspector #543 proceeded to all of the other units and noted that one staff member was sitting in another resident care area at the nursing station. On another resident care area a resident was ringing the call bell for assistance. The inspector noted that there was no staff present on the unit. On the main floor, staff and residents were gathered in the dining room for the supper meal. Inspector #543 notified the Administrator of the residents that were left unattended on two different resident care areas. Inspector #543 asked the Administrator if it was common practice to leave residents unattended on the units. The Administrator stated that "my staff tell me this is common practice." At 5:26pm the Inspectors noted that staff #101 came to the resident care area to answer the call bell.

On January 15th, 2015, inspector #542 observed resident #040 sitting in their wheelchair in their room and they did not have access to their call bell. The resident asked the inspector to pass them the call bell, inspector #542 asked Staff #100 to come to resident #040's room and showed them that this resident did not have immediate access to their call bell. Staff #100 proceeded to clip the call bell to the resident's shirt.

The licensee has failed to ensure that every resident has the right not to be neglected by the licensee or staff. [s. 3. (1) 3.]

Additional Required Actions:

CO # - 902 was served on the licensee. Refer to the "Order(s) of the Inspector".

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

Specifically failed to comply with the following:

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

s. 6. (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. On January 14, 2015 inspector #542 completed a health care record review for resident #043. The care plan indicated that the resident was occasionally incontinent of bowels, usually incontinent of urine and wears an incontinent product . The most recent RAI-MDS assessment indicated that the resident was continent of bowels and occasionally incontinent of urine. Inspector #542 interviewed Staff #106 who stated that the resident does not wear any incontinent products and is continent of both bowel and bladder.

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #043. [s. 6. (1) (c)]

2. Resident #021's present care plan identified that this resident required assistance with bathing, toileting and peri-care, and extensive assistance of one staff person for toileting. Inspector #544 spoke with resident #021 who informed that they are totally independent with toileting. This was confirmed by Staff #102 and #103.

Inspector #544 reviewed the plan of care for resident #021 and identified that the focus, goals and interventions did not have clear direction to guide the provision of care, services and treatment. This plan of care does not address resident #021's present care needs.

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #021. [s. 6. (1) (c)]

3. Inspector #544 conducted a family interview for resident #020. The inspector interviewed this resident's POA who informed that they wrote a letter to the home indicating their concern about the resident's food consumption, the amount they were receiving and their weight loss. The inspector also received a copy of an email from this resident's POA. This email stated that resident #020 was always hungry and losing weight. The POA wanted this matter to be identified and noted. The family of resident #020 asked, via telephone conversation that this issue be resolved and it was not.

Inspector #544 reviewed Resident #020's health care record and identified the resident's weight was as follows:

September 7, 2014 96.3kg
October 7. 2014, 93.9kg
November 7, 2014, 91.1kg (double portions of food (meal) were instituted)
December 7, 2014 89.1kg
January 7, 2015 90.5kg

A care conference regarding Resident #020's diet, preferences and weight loss was requested by resident #020's POA. It was held in November 2014 with this resident's family, the Administrator and all department managers.

Inspector #544 reviewed Resident #020's dietary assessment and portions they were receiving before the care conference in November 2014. Resident #020 was receiving regular portions of food. It was not clear if this resident would ask for more or if more food was offered. There was no documentation that could be found to support this. After the care conference was held, Resident #020 was receiving double portions of all food menu items and fluids and appears satisfied.

Inspector #544 reviewed Resident #020's care plan and identified that it was updated in January 2015 in regards to Resident #20 receiving double portions of the meals and not in November 2014 when the double portions of meals were initiated.

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to Resident #020. [s. 6. (1) (c)]

4. Inspector #544 interviewed Staff #103 who confirmed that Resident #021's care plan has not been updated since January 2014 and there are many changes regarding Resident #021's care needs that are not reflected in their care plan.

The resident's most recent plan of care identified that Resident #021 was totally incontinent. This was true on admission but more recently this resident is totally continent with bladder function and does not require assistance nor does the home provide incontinent products for this resident. Resident #021 is totally continent of bowel and bladder and is totally independent with toileting.

The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

5. During stage 1 of the RQI, it was identified that Resident #021 had incontinence decline and dental and oral problems. These problems were triggered through an MDS assessment completed in October 2014. Inspector #544 reviewed Resident #021's most recent plan of care, assessments, progress notes and doctor's orders. The resident's plan of care indicated, communication, oral/dental and bowel and bladder incontinence problems and noted that Resident #021 was on a specific medication. Inspector #544 could not identify that the specific medication was ever ordered for Resident #021 dating back from admission to present time of inspection. This resident's plan of care did not reflect this change.

Inspector #544 interviewed Staff #102 in regards to Resident #021's continence care issues. Staff #102 stated that his resident's MDS assessment indicated resident was totally incontinent of bladder and bowel function. Staff #102 confirmed that the resident, on occasion wears a brief, and that this resident is totally independent with toileting. This staff member confirmed that Resident #021's plan of care had not been updated since January 2014 and therefore areas of the care plan are not current, not up to date and incorrect.

Inspector # 544 interviewed #103 who confirmed that Resident #021's care plan has not been updated since January 2014 and there are many changes regarding Resident #021's care needs that are not reflected in their care plan. The care plan for Resident #021 indicated that they are totally continent of bowel and bladder and is totally independent with toileting. This resident's most recent plan of care identified that

Resident #021 was totally incontinent. This was true on admission but more recently the resident is totally continent with bladder function and does not require assistance nor does the home provide incontinent products for the resident.

The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

6. Inspector #542 completed a health record review for Resident #040. The most current plan of care accessible to the direct care staff indicated that the resident was to have appliances to prevent contractures and wounds. Inspector #542 observed the resident several times throughout the inspection and noted that these appliances where not in place. Inspector #542 interviewed Staff #106 who stated that the resident does not use the appliances. Staff #100 stated that the resident no longer has a wound.

The licensee has failed to ensure that the Resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the Resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (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 plans of care for residents #020, #021 and #043 set out clear direction to staff and others who provide direct care; and that the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the residents care needs change or care set out in the plan is no longer necessary related to residents #021 and #040, 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. Throughout the course of the inspection, inspectors #542, #543 and #544 observed the following:

-3 resident rooms: the room floors were dirty with black grime, paper and other dried spilled items on the floor
-Resident room: there was grime around the sink area
-Resident unit window sills in all resident rooms were dusty
-Resident unit resident wardrobe tops were very dusty
-Resident unit tub/shower room: shower floor very dirty, black caked grime
-Resident unit TV lounge: had 2, six foot tables, that were dirty and stained on the surface
-Resident unit TV lounge: 2 blue chairs, were dirty and stained on the seats
-Resident unit TV room: one wall, had food specks on the wall
-Resident unit hallway: one, six foot table, was stained and dirty
-Resident room: the caulking around the sink was dirty with black grime
-Resident room: bedside table in was stained with dried fluids
-Resident room: the room floor was dirty
-Resident room: the old Purell Sanitizer container, that is no longer in use as stated by staff and was empty, had black grime and dust on the top of the container
-Resident unit: residents' wardrobe tops were very dusty
-Resident unit: window sills in all resident rooms were dusty
-Resident room: had a large amount of black grime around the caulking of the sink in the bathroom
-Resident unit: window sills in all resident rooms were dusty
-Resident unit: resident wardrobe tops were very dusty
-Resident unit tub/shower room: shower floor very dirty, black caked grime

Inspector #544 observed the following in the main dining room:
- 5/5 feeding stools legs were dirty and had debris on them
- 2 fluorescent light casing are dirty with grime
- microwave oven, in the servery, inside dirty with old food and debris
- 4/6 pull down window blinds were dirty and stained
- 2/8 green dining room chairs were dirty with grime and stains

On January 13, 2014, Inspector #542 observed three, six foot long tables that were being used as dining room tables set up in one of the activity rooms, due to an influenza outbreak. These tables were observed to be very dirty and stained. The RN on duty told inspector #542 that these tables would be covered with table cloths. These three tables were observed to be soiled and badly stained during the initial tour of the home on January 6, 2015.

Inspector #542 immediately informed the Administrator, Staff #108 and the Finance Representative about the lack of cleanliness of these tables. Following this discussion Staff #108 was observed to be cleaning the tables.

Throughout this inspection, the inspectors observed that numerous residents' bed rails were covered with foam rolls and secured with duct tape and were soiled and in disrepair. It was also noted that there were 2 sets of full length bed rail protectors in a resident's room. The vinyl outer cover was ripped exposing the inner foam that was stained and soiled.

The inspectors identified that the handles that the resident's hold during a transfer on the mechanical lifts were caked with grime and dirt on all resident care areas. The inspectors reviewed the checklist for the mechanical lifts and noted that the staff had documented that the lifts where clean.

The inspectors also identified many light switches and electrical cover plates were dirty with black grime.

The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary. [s. 15. (2) (a)]

2. Inspector #544 observed the main dining room and servery and identified the following:

- 1 fluorescent light casing was cracked
- Servery laminate counter-top is lifting from the sink and the finish is wearing off
- Sink taps in the servery were corroded
- 2/2 hand washing sinks were chipped and there was debris around the caulking of the sink- laminate is wearing off
-Resident room: the walls were badly marked and scratched

The licensee has failed to ensure that the home, its furnishings and equipment maintained in a safe condition and in a good state of repair. [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 kept clean and sanitary and are maintained in a safe condition and in good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. In a family interview during stage 1 of the inspection, Inspector #543 was informed by a resident's family member that the resident has to wait too long for assistance. On January 14, 2015, Inspector #543 requested the home's contingency or back up plan for staffing (i.e. short staffed, shift replacement). The Administrator informed the inspector that the sheets that are in the staffing binders outline how sick calls will be replaced. The inspector reviewed these sheets and identified that they do not outline what the home is to do if a unit is short and unable to replace a staff member. These sheets did not include a back-up plan for nursing and personal care staffing that addresses when staff cannot come to work.

On January 15, 2015, inspector #543 attempted to further clarify with the Administrator the requirement for a staffing back-up plan. The Administrator stated that the home deals with those situations on a case to case basis. The Administrator confirmed that there is no specific written plan that outlines or describes a back-up plan for nursing and personal care staffing that addresses when staff cannot come to work. She also confirmed that the home does not have a policy that addresses when a staff member cannot come to work.

The licensee failed to ensure that the home has a staffing plan that includes a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work. [s. 31. (3)]

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 has a staffing plan that includes a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work, including staff who must provide the nursing coverage required under subsection 8(3) of the Act and O. Reg. 79/10, s. 31 (3), to be implemented voluntarily.

WN #6: 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. Inspector #544 completed a health record review for Resident #021 and identified that on admission, the resident was incontinent of urine and bowel. This was confirmed by Staff #103. The inspector did not find any documentation to support that a bowel and bladder assessment was completed for resident #021 upon their admission. The inspector also reviewed Resident #021's plan of care which did not address this resident's care needs related to their urinary and/or bowel continence nor did this plan of care address interventions focused on promoting continence through a resident focused scheduled toileting program or regaining bladder control through a structured resident focused bladder retraining program.

The inspector spoke with Staff #102 and #103 who confirmed that a bladder and bowel assessment was not completed for Resident #021 and there have been significant changes in their bladder and bowel pattern over the months since their admission. It was also confirmed that the resident's plan of care had not been updated or revised since the resident's admission.

Inspector #543 spoke with Staff #103 who stated that all residents receive continence care assessments upon admission and stated that if residents require any incontinence products they are added to the TENA list (for tracking, sizing, etc.). Upon admission the resident's toileting routine is also monitored on a 7 day flow sheet. This staff member also stated that if at any time the resident has a significant change in their continence status, a reassessment will be completed.

Inspector #544 reviewed the home's policy regarding Continence Care which stated that residents will be assessed on admission and quarterly thereafter at a minimum for both urinary and bowel continence. This policy stated that based on the resident assessment of both bowel and urinary continence, a resident focused care plan will be developed to address resident care needs related to their urinary and/or bowel continence.

The licensee failed to ensure that the home's Continence Care Policy, required by the section 51 of the Regulation was complied with. [s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. On January 8, 2015 Inspector #542 completed a health record review for Resident #040. The most recent RAI/MDS assessment indicated that the resident had unclear speech and is difficult to understand. Inspector #542 interviewed Staff #100 and #106 who stated that the resident's speech can be slurred and difficult to understand. The most recent plan of care did not include an assessment of the resident's communication abilities.

The licensee has failed to ensure that the plan of care based on an interdisciplinary assessment of the resident's communication abilities, including hearing and language. [s. 26. (3) 3.]

2. Inspector #542 completed a health record review for Resident #041. The most current plan of care did not indicate the resident's communication abilities. Inspector #542 interviewed Staff #106 who stated that the resident typically uses hand gestures and there is a communication barrier as the resident cannot speak english. This staff member also stated that sometimes it can be difficult to understand the resident's needs and that they need time to communicate.

The licensee has failed to ensure that Resident #041's plan of care is based on an interdisciplinary assessment of the resident's communication abilities. [s. 26. (3) 3.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector #544 reviewed the health care records from unit two and identified that the following residents, heights were not measured in 2014; Resident #023, #031, #032, #020, #026, #028, #033, #021, #034, #029. These residents', heights were last measured in 2013. Inspector #544 spoke with Staff #103 who stated that height measurements were only completed for residents who were new admissions in 2014, no other height measurements were taken.

The licensee failed to ensure that the home's Nutrition Care and Hydration Program included a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter. [s. 68. (2) (e) (ii)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. On January 6, 2014 Inspector #542 observed the lunch dining service on a resident unit. Several of the residents on this unit were receiving trays due to being on isolation in their room. The inspector noted that several of the trays of food were left on top of the nursing station desk uncovered and unattended for approximately seven minutes. The inspector then observed that two trays of uncovered food were brought to two separate residents and were left uncovered on their chairs for 10 minutes before a staff member came to assist these residents.

The licensee failed to ensure that all food and fluids in the food production system are served using methods to prevent adulteration, contamination and food borne illness. [s. 72. (3) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping
Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. Throughout the course of the inspection, Inspectors #542, #543 and #544 observed the following:

-Resident room: bathroom had a strong offensive odour, not distinguishable
-Resident room: bathroom had a strong offensive odour of urine
-Resident room: bathroom had a strong odour of urine
-Resident unit tub/shower room: had an offensive odour of urine

The licensee failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following:

s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).

Findings/Faits saillants :

1. Throughout the inspection, Inspector #544 observed small flies in the bathroom of two residents' rooms. The inspector identified five large brown bugs in the dishwasher of the servery on the main floor. Inspector #544 immediately notified Staff #108.

Inspector #544 spoke with Staff #108 who stated that the home has had a problem with "German Roaches" since November 2014. This staff member also stated that a pest control company comes in twice a week to check on things. The home does not use the dishwasher in the servery and has asked numerous times to have the dishwasher removed. These findings were brought to the attention of the Administrator and the Maintenance supervisor.

As part of organized programs of housekeeping and maintenance services under clauses 15 (1) (a) and (c) of the Act, the licensee failed to ensure that immediate action is taken to deal with pests. [s. 88. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. Inspector #544 observed that some taps were leaking and that the silver finish was corroded and wearing off. The Inspector spoke with Staff #105 who confirmed that taps are being replaced when they leak and the corrosion is such that the taps will not turn off. Staff #105 also confirmed that plumbing fixtures, toilets, sinks, and washroom fixtures and accessories are not maintained and kept free of corrosion and cracks at this time. They hope to replace sinks, taps and counter-tops starting shortly at the rate of one to two per month. Staff #105 told the inspector that they are only able to repair broken pipes and elbows under the vanity that are leaking and that they have replaced a few sets of taps in the last several months.

Inspector #544 interviewed Staff #111 and the Administrator who confirmed that there is a plan to replace sinks and counter-tops two or three at a time. They stated that there are no capital dollars for these concerns, and that this year's monies are going towards replacing windows in the home over the period of 2015-2018.

The licensee has failed to ensure that that procedures are developed and implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks. [s. 90. (2) (d)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 138. Absences

Specifically failed to comply with the following:

s. 138. (6) A licensee of a long-term care home shall ensure that before a resident of the home leaves for a medical absence or a psychiatric absence,
(b) notice of the resident's medical absence or psychiatric absence is given to the resident's substitute decision-maker, if any, and to such other person as the resident or substitute decision-maker designates,
(i) at least 24 hours before the resident leaves the home, or
(ii) if circumstances do not permit 24 hours notice, as soon as possible. O. Reg. 79/10, s. 138 (6).

Findings/Faits saillants :

1. In a family interview on January 8, 2015, Inspector #544 spoke with Resident #020's POA who informed the inspector that they were not made aware of the resident's admission to the hospital in the past few months. Inspector #544 reviewed this resident's health care record, progress notes and other assessments and identified that Resident #020 was hospitalized on two occasions in 2014.

On January 13, 2015, Inspector #544 spoke with Resident #020's POA who emphasized that they had not been notified of the resident's admission to hospital in the past few months. They reiterated that they were not informed of the admission to hospital until the resident was being discharged back to the home, ten days later. The resident's progress notes did not indicate that the family were advised of this admission to hospital.

Inspector #544 spoke with Staff #102 who confirmed that there was a new staff member on duty and may have forgotten to call the family regarding Resident #020's admission to the hospital.

The licensee has failed to ensure that Resident #020's substitute decision-maker, if any, and to such other person as the resident or substitute decision-maker designates were notified of this resident's medical absence from the home. [s. 138. (6) (b)]

Issued on this 27th day of February, 2015

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : TIFFANY BOUCHER (543), FRANCA MCMILLAN (544), JENNIFER LAURICELLA (542)

Inspection No. / No de l'inspection : 2015_282543_0001

Log No. / Registre no: T-000116-14

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jan 15, Feb 26, 2015

Licensee / Titulaire de permis : Chartwell Master Care LP
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

LTC Home / Foyer de SLD : WHITE EAGLE RESIDENCE
138 DOWLING AVENUE, TORONTO, ON, M6K-3A6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Adyanes Lachowski

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To Chartwell Master Care LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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).

Order / Ordre :

The licensee shall ensure that the resident-staff communication and response system can be easily seen, accessed and used by residents at all times.

Grounds / Motifs :

1. On January 14th, 2015 Inspector #542 and #543 were on a resident care area. Inspector #542 proceeded to resident # 040's room and found resident lying in bed. The resident asked Inspector #542 if there was a nurse available. Inspector advised the resident to pull their call bell. Resident #040 attempted to pull their call bell cord however it was caught on the drawer of their bedside table and they were unable to engage the call bell. At 5:06pm, Inspector #542 assisted this resident with engaging their call bell.

On January 15th, 2015, Inspector #542 observed resident #040 sitting in their chair in their room and this resident did not have access to their call bell. This resident asked the Inspector to pass them the call bell. Inspector #542 asked registered staff #100 to come to resident # 040's room and showed them that this resident did not have immediate access to their call bell. Staff #100 proceeded to clip the call bell to this resident's shirt.

The licensee failed to ensure that the home's resident-staff communication and response system can be easily accessed and used by residents at all times. (542)

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

Order # / Ordre no : 902 **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 so that every resident has the right not to be neglected by the licensee or staff. The licensee will ensure that staff are deployed in all resident care areas to meet all resident care needs and residents are not left unattended.

Grounds / Motifs :

1. On January 14th, 2015 Inspector #542 and #543 were on a resident care area and noted that two residents were in bed. Both Inspectors noted that there were no staff members present on this unit ; to monitor or provide care to these two residents. Resident #040 asked Inspector #542 if there was a nurse available. The Inspector informed the resident that there was no nurse on the unit and that they should pull the call bell. Resident #040 attempted to pull their call bell however they were unable to do so as the pull cord was stuck in a drawer of their bed side table. Inspector #542 assisted the resident with pulling their call bell at 5:06pm. Both Inspectors waited on the unit for 20 minutes and observed that no staff members were coming to the unit to answer this resident's call bell. Inspector # 543 proceeded to all of the other units and noted that one staff member was sitting at the nursing station on a unit. On another resident care area #030 pulled the call bell for assistance. The Inspector noted that there was no staff present on that resident care area. On the main floor, staff and residents were gathered in the dining room for the supper meal. Inspector #543 notified the Administrator, of the residents that were left unattended on two different resident care areas. Inspector # 543 asked the Administrator if it was common practice to leave residents unattended. The Administrator stated that "my staff tell me this is common practice." At 5:26pm the Inspectors noted that staff member #101 came to the resident care area to answer the call bell.

On January 15th, 2015, Inspector #542 observed resident #040 sitting in their chair in their room and they did not have access to their call bell to call for assistance. This resident asked the Inspector to pass them the call bell so that they could call for assistance. Inspector #542 asked registered staff #100 to come to resident #040's room and showed them that this resident was not able to call for assistance.

The licensee has failed to ensure that every resident has the right not to be neglected by the licensee or staff.

(542)

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

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. 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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that will;

-clearly indicate when activated where the signal is coming from

This plan shall be submitted in writing to Tiffany Boucher, Long Term Care Homes Nursing Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564-3133 or email Tiffany.Boucher@ontario.ca. This plan must be submitted by March 13, 2015.

Grounds / Motifs :

1. On January 14, 2015 inspectors #542 and #543 were on a resident care area. Inspector #542 proceeded to Resident #040's room, and the resident asked the inspector if there was a nurse available. The inspector advised the resident to pull their call bell. Inspector #542 proceeded to the main floor where staff and residents where gathered in the dining room for the supper meal, while inspector #543 stayed on the unit. The inspector noted that the call light (on the main floor) was lit up in the hallway however no sound was coming from it, therefore the staff did not know that a resident was calling for assistance. The call light did not indicate which resident required assistance nor did it identify the resident care area. The Administrator stated that staff have to go to each resident care area in order to identify which resident is calling for help.

The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that, clearly indicates when activated where the signal is coming from (Leg/Ref. r. 17. (1) (f)).
(542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2015

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that in the case of a system that uses sound to alert staff that;

-the system is functioning so that the level of sound is audible to staff

This plan shall be submitted in writing to Tiffany Boucher, Long Term Care Homes Nursing Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564-3133 or email Tiffany.Boucher@ontario.ca. This plan must be submitted by March 13, 2015.

Grounds / Motifs :

1. On January 14, 2015 Inspector #542 and #543 were on a resident care area. Inspector #542 proceeded to Resident #040's room and found a resident lying in bed. The resident asked Inspector #542 if there was a nurse available, the inspector advised the resident to pull their call bell. Resident #040 attempted to pull their call bell cord however it was caught on the drawer of their bedside table and they were unable to engage the call bell system. At 5:06pm, inspector #542 assisted the resident with engaging their call bell. Inspector #542 proceeded to the main floor where staff and residents where gathered in the dining room for the supper meal, while inspector #543 stayed on the unit. The inspector noted that the call light (on the main floor) was lit up in the hallway however no sound was coming from it, therefore the staff did not know that a resident was calling for assistance. The call light did not indicate which resident required assistance nor did it identify the resident care area. Staff #101 informed the inspector that the call bell system was not working correctly.

The Administrator informed the inspectors that the staff will go to each unit in order to identify which resident is calling for help. They confirmed that the light did not identify which unit or room the call originated.

The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that, 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 (Leg/Ref. r. 17. (1) (g)).
(543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 15th day of January, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Tiffany Boucher

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