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

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 5, 2015	2014_378116_0014	T-132-14	Resident Quality Inspection

Licensee/Titulaire de permis

INA GRAFTON GAGE HOME OF TORONTO
40 Bell Estate Road SCARBOROUGH ON M1L 0E2

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

INA GRAFTON GAGE HOME
40 Bell Estate Road SCARBOROUGH ON M1L 0E2

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

SARAN DANIEL-DODD (116), NICOLE RANGER (189), NITAL SHETH (500), VALERIE PIMENTEL (557)

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): October 3, 6, 7, 8, 9, 10, 14, 15, 16, 17, 20, 21, 2014.

The following inspections were conducted in conjunction with the Resident Quality Inspection (RQI):T-808-13, T-810-13, T-183-14, T-222-14, T-301-14, T-308-14, T-378-14, T-416-14, T-588-14, T-660-14, T-633-14, T-741-14 (follow-up), T-801-14, T-850-14, T-856-14, T-867-14, T-878-14.

During the course of the inspection, the inspector(s) spoke with the executive director (ED), acting director of care (DOC),assistant director of care (ADOC), food service manager, environmental service manager, programs manager, activation staff, registered nursing staff, personal support workers (PSW),dietary aides, laundry aide, housekeeping, maintenance technician, family and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing
Trust Accounts

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

26 WN(s)
10 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

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

Review of the home's continence and bowel management program and interviews held

with the acting director of care (DOC) and Executive Director (ED) confirmed that an annual resident satisfaction evaluation of continence care products has not been conducted within the home. [s. 51. (1) 5.]

2. The licensee has failed to ensure that there is a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes.

Review of the health record for resident #042 revealed that on a specified date, an identified PSW observed the clothing and bed sheets of resident #042 to be wet and soiled with urine.

Interviews held with registered staff and personal support workers (PSW) confirmed that there have been multiple occasions where continence care products were not available upon the unit and within the home to provide residents with sufficient changes to remain dry and comfortable. [s. 51. (2) (f)]

3. Staff interviews revealed that there were insufficient continence care products available for residents at all times. Staff reported to the inspector that there are multiple times where there are no continence care products available for residents and the staff are forced to use liners in-between the resident continence product in order to keep the residents dry. Staff members reported to the inspector that they were informed by management that due to funding they are provided one continence brief per shift per resident. PSWs reported to the inspector that they brought this issue to the management's attention during a staff meeting. Staff reported that this is still an ongoing issue in the home. [s. 51. (2) (f)]

4. The written plan of care for resident #023 identifies that the resident is frequently incontinent of urine and requires medium incontinence brief to be clean and comfortable.

Interviews held with registered staff and PSW's confirmed that during a specified period, continence care products were not available within the home which resulted in resident #023 not receiving the required continence brief changes. Registered staff members and PSW's communicated to the inspector that residents were observed to be left in soaked continent products when coming on for an identified shift. [s. 51. (2) (f)]

5. Written communication was provided to the inspector by an identified staff member where, on a identified date, the acting DOC was notified that there were only medium

size brief available for the residents.
Response received from the acting DOC indicated that briefs are delivered on a specified weekday. The registered staff member informed the inspector that due to the response being received the day after the stock was delivered residents that required large briefs were provided with medium briefs until the following continence care delivery. [s. 51. (2) (f)]

6. The licensee has failed to ensure that the resident who requires continence care products have sufficient changes to remain clean, dry and comfortable.

An interview with an identified PSW revealed that on an identified date, resident #051 did not have sufficient changes to remain clean, dry and comfortable. Staff reported that resident #051 requires frequent changes of his/her continence product. The PSW indicated that because there were not enough continence care products available for the resident, the PSW had to leave the resident with a wet diaper during a specified shift.

Record review indicated that resident #051 is on a toileting schedule and is to be checked every two hours per shift for incontinence.

An interview with an identified PSW revealed that on an identified date, he/she did not have assistance to change four identified residents who required continence care. The PSW revealed that because he/she was alone on the unit and did not have assistance to change the four residents, the residents were left with wet briefs during the shift. [s. 51. (2) (g)]

7. Review of the health record for resident #042 revealed that on a specified date, at the commencement of an identified shift, an identified PSW observed the clothing and bed sheets of resident #042 to be wet and soiled with urine.

Interviews held with registered staff and PSW's confirmed that there have been multiple occasions where continence care products were not available upon the unit and within the home to provide residents with sufficient changes to remain dry and comfortable. [s. 51. (2) (g)]

8. Review of the health record for resident #023 revealed that on an identified date, during a specified shift, resident #023 complained to a registered staff member that he/she was calling for help and no one attended to him/her. The resident was observed by the PSW and registered staff to be soaking wet with stool and urine.

Interviews held with the acting DOC and associate director of care (ADOC) confirmed that there were errors in the count for continence care products which resulted in inadequate amounts being available to provide sufficient changes to residents to remain clean, dry and comfortable. [s. 51. (2) (g)]

9. The licensee has failed to ensure that residents provided with a range of continence care products based on their individual assessed needs.

Resident #022 is identified as being incontinent of urine and requires medium size brief.

During an interview with the Power of Attorney (POA) of resident #022, it was reported that the improper size of continent briefs are being provided to the resident which is resulting in his/her clothing being wet and soiled with urine. The concerns were brought to the attention of the charge nurse and ED who agreed to have the resident re-measured in order to meet his/her individual assessed needs. The home was unable to provide any documentation or confirmation of reassessment of brief sizing for resident #022.

An interview held with the ADOC confirmed that a range of continence care products are not available based on individual based needs and the home is following a directive put in place by the previous DOC whereby, only medium and extra large briefs are ordered. [s. 51. (2) (h) (i)]

10. The licensee has failed to ensure that residents are provided with a range of continence care products that properly fit the residents.

Through review of the home's continence products inventory and interviews held with staff it was revealed that the home only provides two sizes of brief.

Interview held with the ADOC confirmed that a directive was put in place by the former DOC for the removal of small briefs and to only order medium and extra large brief. The ADOC confirmed that the current continent products available do not provide a range of continence care products that properly fit the residents which results in leakage. [s. 51. (2) (h) (ii)]

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 O.Reg 79/10, s. 9. Doors in a home
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The following area of non compliance was identified on June 16, 2014 during inspection# 2014_357101_0016 where an order was issued and remains outstanding as of this inspection.

The licensee failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors kept closed and locked when they are not being supervised by staff.

During the initial home tour, the inspector observed the doors leading to the server area of the kitchen located on an identified unit did not lock. The first door into the back hallway did not have a lock on the door, the second door that leads into the back entrance of the server vestibule area was ajar from the door frame, it did not close and was not able to be locked. The back door entrance into the server had a key pad on the door that allowed access into the server area, the key pad did not function and did not lock the door.

Interviews with the ESM and acting ED confirmed that the doors and locks leading to non-residential areas did not function properly and that residents could access these areas unsupervised. [s. 9. (1) 2.]

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 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).

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provides a staffing mix that is consistent with residents' assessed care and safety needs.

For a specified period, the staffing level on an identified shift decreased by one PSW. The home has four floors with 32 residents per floor. There is one PSW per floor and two float PSWs that are assigned to float between two floors.

Interviews held with PSWs that work various shifts indicated that there is insufficient staff to meet the residents' needs on the specified shift. The PSWs reported there were multiple incidents where a second PSW was not available to assist the assigned PSW and residents did not receive continence care to remain clean and dry.

Staff interviews revealed that on the specified shift, there are a number of residents who require monitoring for wandering and behavioural issues and residents who require two-person assistance for toileting and care. Staff reported in addition to these resident care tasks, they are also required to respond to call bells, complete point of care documentation and additional tasks such as cleaning residents` wheelchairs.

Staff reported that the residents' situated on the heaviest unit in the home require higher care assistance. Staff reported that, as per job routine for the specified shift, the float PSW is required to assist on the unit for one hour for the first round, and then return to assist with the second round for another hour. Staff report that this is an insufficient amount of time to assist the residents who required two person assistance or monitoring, and they are unable to complete their assigned work before moving on to assist the other unit.

Two identified PSWs reported to the inspector that on two identified occasions on the night shift, they were left alone on the unit to care for 32 residents. Interview with the staffing coordinator revealed that over a specified five-month period, there were two shifts where a PSW called in sick and the shift and was not filled according to the current staffing plan.

A critical incident report was submitted to the Director stating that on a specified date, two identified residents were found soaking wet by both their POA's. The POA's had informed the staff of this occurrence. Interview with the identified PSW revealed that during rounds, the float PSW came to the floor and started to assist the PSW with care on the identified unit, but was unable to finish with care for the residents on the opposing unit as the designated hour was completed and the float PSW had to return to the other floor to assist with care. The PSW reported that there were four residents on the opposing unit who required two person assistance for continence care but did not receive it as there was not a second person to assist the PSW. Record review for the four identified residents confirmed that each resident required two person assistance for toileting.

An identified registered staff member reported to the inspector that the current staffing on an identified shift does not meet the needs of residents as the residents on an identified unit are unpredictable with their wandering and behaviours and an identified unit is heavy care requiring two person staffed at all times on the floor. The registered staff reported that safety is a concern for the residents as the PSWs leave the floor unattended to clean the wheelchairs at the back of the unit.

The acting ED reported in an interview with the inspector that the current staffing plan for the specified shift was based on an assessment of the financial labour distribution in the home.

The ADOC and acting ED reported that a staffing assessment was conducted by the previous Chief Nursing Officer, but they were unable to provide documentation to support this statement. [s. 31. (3)]

2. The licensee has failed to ensure that there is a written record of each annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The ED for the home was unable to provide the inspector with a written record of the annual evaluation of the staffing plan for the home. [s. 31. (4)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident's right to be treated with courtesy and respect and in a way that fully recognizes his/her individuality and respects his/her dignity is fully respected and promoted.

An interview held with resident #050 revealed that on an identified date, he/she activated the call bell for assistance to go the bathroom. An identified PSW who was assigned to care for the resident, came into the room and was not happy that he/she had to assist the resident to the toilet. The resident reported that the toilet seat was unclean and pointed this out to the PSW. The resident reported that the PSW told stated "well you would have to clean it yourself, I do not clean toilets and I do not clean teeth". Resident #050 reported to the inspector that he/she felt angry that the PSW spoke to him/her in this manner. Resident #050 stated that he/she reported this to the management and was told that this is unacceptable, yet the PSW still continues to provide care to the resident.

An interview held with the identified PSW confirmed the above incident and stated that he/she told the resident that he/she does not "sanitize toilets" and does not assist the resident with oral care. [s. 3. (1) 1.]

2. An interview held with resident #024 revealed that an identified PSW is rough while providing personal care and does not treat him/her with respect and dignity. Resident #024 indicated that he/she has not reported the concerns to management.

Interviews held with the identified PSWs indicated that resident #024 has restrictions in mobility which makes it difficult at times to provide personal care. The PSW's revealed that they need to apply force at times to access identified limbs of the resident's body and at times, the resident will express that he/she is experiencing pain. Both PSWs confirmed that the force applied to clean the resident can be portrayed as rough towards a resident and as not respecting resident #024's dignity and individuality. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity is fully respected and promoted, to be implemented voluntarily.

WN #5: 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident’s plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Review of the health record for resident #042 and interviews held with registered and direct care staff members confirmed that the resident is incontinent x2 and uses medium sized brief to manage incontinence.

The plan of care for resident #042 does not identify the resident's incontinence level and the required use of incontinent brief. The plan of care did not set out clear directions to manage resident #042's incontinence. [s. 6. (1) (c)]

2. The quarterly minimum data set (MDS) assessment conducted on an identified date, indicated that resident #004 was confined to bed all or most of the time, requiring two person assist and his/her condition had deteriorated. The written plan of care from a specified date, revealed resident #004's preferred sleep and rest patterns in order for the resident to function safely and without fatigue, allowing the resident to attend different activities in the home.

Interviews with PSWs and registered nursing staff confirmed that the resident receives total bed care, was no longer up during the day and was bedridden. Registered nursing staff and the ADOC confirmed the resident's care plan had not been updated and did not provide clear directions to direct care providers. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the staff and others who provide direct care to a resident have convenient and immediate access to the resident's plan of care.

A review of the written plan of care for resident #021 indicated to use side rail padding to bed-rail to minimize bruising and injuries.

An interview with an identified PSW confirmed that the resident uses one side rail to minimize bruises and injuries to his/her extremities. The family requested to use two full rails when the resident is not in his/her room to prevent a wandering resident to use resident #021’s bed.
Interview with the charge nurse confirmed that application of side rail padding to the bed rail is not added into the kardex, therefore PSWs do not have access to it.

Interview with the resident assessment instrument (RAI) coordinator confirmed that the PSW should have access to the plan of care and above mentioned intervention should be added to the kardex. [s. 6. (8)]

4. A review of the written plan of care for resident #002 indicated that resident #002 may

use side rails for transferring.

Interview with an identified PSW confirmed that the resident has one quarter bed rail up but is unaware why the resident needs it.

Interview with the registered nursing staff confirmed that the plan of care indicates to use side rails for transfers. This intervention was not added to the kardex and the PSWs have access to the kardex only.

Interview with the RAI coordinator confirmed that the PSWs should be provided with access to the resident's plan of care. [s. 6. (8)]

5. The licensee has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary.

The quarterly MDS for a specified three-month duration, indicated that resident #003 had incidence of worsening function in daily activities in identified areas. The written plan of care effective over an identified six-year period, indicated that the resident was able to transfer himself/herself using an assistive device from one surface to another and is a one person supervision bed mobility, eating directions was to offer and document food and fluid intakes, and toileting: provide encouragement ,supervision and reminders.

Staff interviews and record review revealed that the resident was confined to bed, had to be fed, and was incontinent of bowel and bladder. Interview with the registered nursing staff confirmed that the written plan of care under the bed mobility, transferring, eating, and toilet use section was not reviewed and updated over the identified six-year period to reflect resident's care needs. [s. 6. (10) (b)]

6. Resident #022's written plan of care documents the need for avoidance of social isolation due to cognitive decline as exhibited by difficulty conversing and interacting with others.

An interview with the programs manager identified that due to the nature of the resident's illness he/she has experienced cognitive decline and should be involved in small group sensory programs and activities based on his/her remaining strengths. Further, the programs manager confirmed that the quarterly review conducted on an identified date, did not reassess and revise the resident's recreational and social care needs. The

written plan of care was revised and updated after the inspector's inquiry, to include interventions that include sensory programs for the resident. [s. 6. (10) (b)]

7. Record review revealed resident #003 had a decline in transferring, toileting and eating. The written plan of care indicated the resident was able to transfer self, required encouragement, supervision and reminders with toileting and required supervision with eating.

Staff interviews with a PSW and registered nursing staff confirmed the resident was bed ridden, refused to eat or drink and was incontinent of bowel and bladder. The plan of care was not revised to reflect resident #003's current care needs. [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 the following:
- the plan of care sets out clear directions to staff and others who provide direct care to the resident
- staff and others who provide direct care to a resident have convenient and immediate access to it and,
- resident's are 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, 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. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The licensee's policy entitled 'expiry and dating of medications' (Policy#4-18) states the following: "examine the expiry dates of all medications on a regular basis. Establish a schedule and designate staff to be responsible for this regular expiry check. Remove any expired medications from stock and order replacements from the pharmacy".

Expired medications were observed in an identified medication storage room and medication cart.

Interviews held with registered staff members and the acting DOC confirmed that the home's established schedule for reviewing expired medications is to be conducted on a monthly basis and it was not followed. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 10. Elevators

Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. O. Reg 79/10 section 10(1) was issued as a written notification on June 16, 2014 during inspection# 2014_357101_0016 and during this inspection.

The licensee has failed to ensure that the elevators are equipped to restrict access to areas that are not to be accessed by residents.

All elevators in the home do not restrict resident access to the basement area once the resident has entered the elevator from a resident home area. The basement area is a restricted area to residents as it contains only services that maintain the home (i.e. laundry, kitchen, boiler, receiving area, etc) as well as staff areas.

An interview held with the acting ED confirmed that there is no system in place to monitor residents accessibility to the basement. [s. 10. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the elevators are equipped to restrict access to areas that are not to be accessed by residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 10. Recreational and social activities

Specifically failed to comply with the following:

s. 10. (2) Without restricting the generality of subsection (1), the program shall include services for residents with cognitive impairments, and residents who are unable to leave their rooms. 2007, c. 8, s. 10 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the recreational and social activities program includes services for residents with cognitive impairments and residents who are unable to leave their room.

Resident #022 is identified as being cognitively impaired and reliant on staff for social interaction. The written plan of care indicates that resident #022 should be involved in programs on a weekly basis to avoid social isolation due to cognitive decline. Review of the recreation participation record for an identified two-month period, indicated the resident participated in two activities each month.

Review of the recreational program and interviews held with an activation aide and the programs manager revealed that the home currently provides one to one programming for cognitively impaired residents who are deemed as priority. An interview held with the programs manager confirmed that resident #022 is not on the priority list for one to one. An interview with the programs manager confirmed that the home is currently not meeting the needs of those cognitively impaired residents that are not identified as priority due to staffing. Furthermore, the programs manager confirmed that the current recreational and social programming provided to resident #022 is not meeting the resident's needs. [s. 10. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the recreational and social activities program include services for residents with cognitive impairments and residents who are unable to leave their room, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The inspector observed during the initial home tour the activity area and the dining room sitting areas in an identified home area had multiple screened windows that were open to the outdoors and these areas were accessible to residents. The window openings were measured by the inspector and found to be wider than 15 centimetres.

Interviews held with the ESM and acting ED confirmed the windows opened more than 15 centimetres and the areas were accessible to the residents. [s. 16.]

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 every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are 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. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following are developed to meet the needs of residents with responsive behaviours: written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

Record review revealed that the home initiated a dementia observation system (DOS) tool to screen resident #007 over three different time frames to identify behaviors and the time the behaviors occurred. The DOS tool is to be completed for 24 hours per day for seven days.
The DOS tool was completed on a consistent basis over the observed period.

Interviews with the registered nursing staff, behavioural team lead and DOC confirmed the DOS tool for screening resident #007 was incomplete and did not identify behavioural triggers for any 24 hour period over 7 days. [s. 53. (1) 1.]

2. The licensee has failed to ensure that a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Record review revealed the matters referred to in subsection (1) were not evaluated on an annual basis. Interviews with the responsive behavior team lead, DOC and acting administrator confirmed the evaluation was not conducted in 2013. [s. 53. (3) (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 written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other are developed to meet the needs of residents with responsive behaviours, to be implemented voluntarily.

WN #11: 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 :

1. The licensee has 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.

Pre-poured medications were observed to be stored on top of a medication cart on an identified unit. The medication cart was left unattended and unsupervised. An interview held with the assigned registered staff member confirmed that medications should 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. [s. 126.]

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 labeled 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 #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On an identified date, a medication cart on an identified unit was observed to be unlocked and unattended and stored in the dining room vicinity which was accessible to residents and visitors to the home.

Interviews with the assigned registered staff confirmed that the medications should be locked at all times when unattended. [s. 129. (1) (a)]

Additional Required Actions:

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

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 232. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home. O. Reg. 79/10, s. 232.

Findings/Faits saillants :

1. The licensee failed to ensure that the records of the residents of the home are kept at the home.

An identified complainant reported that during a discussion with the home's management staff, it was revealed that the Administrator takes the residents' documents which require shredding, to an identified location, and destroys the documents by burning them.

Interview with the Administrator confirmed that he/she takes the residents' documents to an identified location and keeps the documents in a locked garage for about 10 days before burning the documents. The Administrator reported that other individuals have access to the locked garage. [s. 232.]

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 records of the residents of the home are kept at the home, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Observation conducted on an identified date, revealed one quarter bed rail used for resident #024's bed.

A review of the home's policy #RC-0600-03, titled Side Rails, dated December, 10, 2014, revealed that "all residents must be assessed by the RN via the side rail decision tree to determine if side rails will indeed decrease the risk of injury or if alternatives are more appropriate."

Interview with the PSW confirmed that resident #024 uses one side rail for security.

Interview with the registered nursing staff confirmed there is no assessment available in the resident's chart.
Interview with the RAI Coordinator confirmed that, the assessment should be completed by the RN for use of side rails for the above mentioned resident according to the home's policy. [s. 15. (1) (a)]

2. Observation conducted on an identified date, revealed two full bed rails used for resident #021's bed.

An interview with a PSW confirmed that he/she uses one side rail for the above mentioned resident and for all residents. The family requested to use both full rails when the resident is not in his/her room to prevent a wandering resident to use resident #021's bed.

Interview with the registered nursing staff confirmed that they are using both full bed rails for the above mentioned resident to prevent a wandering resident using resident #021's bed. There is no assessment available in the resident's chart completed by an RN for use of side rails.

Interview with the RAI Coordinator confirmed that, the assessment should be completed by the RN for use of side rails for the above mentioned resident according to the home's

policy. [s. 15. (1) (a)]

3. Observation conducted on an identified date, revealed one quarter bed rail used for resident #002's bed.

Interview with the PSW confirmed that he/she uses one quarter side rail for the above mentioned resident.

Interview with the registered nursing staff confirmed that they use one quarter bed rail for the above mentioned resident to prevent a wandering resident using resident #021's bed. There is no assessment available in the resident's chart completed by RN for use of side rails.

Interview with the RAI Coordinator confirmed that, the assessment should be completed by the RN for use of side rails for the above mentioned resident according to the home's policy. [s. 15. (1) (a)]

WN #15: 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:
4. Vision. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
9. Disease diagnosis. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care is based on, at a minimum, interdisciplinary assessment of the resident's vision.

A review of the plan of care for resident #025 does not indicate any information about the resident's vision.

Interview with the registered nursing staff confirmed that plan of care is not developed for the above mentioned resident's vision.

Interview with the RAI Coordinator confirmed that the resident's plan of care should be based on an interdisciplinary assessment of the resident's vision. [s. 26. (3) 4.]

2. The licensee has failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the resident's disease diagnosis.

Record review of resident #004, revealed that the physician identified the resident has severe dementia, general condition and long term prognosis is not favorable.

Interviews held with a PSW and registered nursing staff confirmed the resident's disease diagnosis was not included in the resident's plan of care. [s. 26. (3) 9.]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents’ Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Residents’ Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee, within 10 days of receiving the advice, respond to the Residents’ Council in writing.

A review of Residents’ Council minutes binder 2014, revealed only two Residents’ Council concern forms for August and September 2014 were available.

Interview with the director of recreation and program services confirmed that the home has started a new procedure for initiating Residents’ Council concern form for each of the concerns raised by the Residents’ Council during meetings. This concern form is forwarded to the respective manager and returned to the President of the Residents’ Council within seven days, the President approves and signs the form. Prior to August 2014, immediate concerns received a verbal response by the respective manager to the President of the Residents’ Council within seven days and documented in the minutes. The concerns which were not immediate to address were documented in the minutes of that day's meeting. Responsible managers for those concerns were invited to the following meeting and the managers verbally responded to the concerns. Those action plans were documented in the minutes of that particular day. The copies of these minutes were provided to the members of the Residents’ Council in a following meeting. Not all concerns raised by the Residents’ Council were responded to in writing and or within 10 days of receiving them. [s. 57. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Observation conducted on an identified date during the lunch meal service revealed that the posted menu had potato salad, and cod nuggets for lunch.

Inside the servery the dietary aide had mashed potatoes and pureed cod.

Interview with the dietary aide confirmed that the cook did not provide pureed potato salad.

Interview with the cook and food service supervisor (FSS) confirmed that the therapeutic menu and standardized recipes indicate to provide pureed potato salad and pureed cod nuggets to the residents on pureed texture, however they provided mashed potato. [s. 71. (4)]

WN #18: 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,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all foods in the food production system are prepared using methods to, preserve taste, nutritive value, appearance and food quality.

Observation conducted on an identified date during an identified meal service revealed that the minced and pureed carrot raisin salad was too sticky.

Interview with the cook confirmed that they added thickener to the above mentioned item to prevent it from becoming watery.

A review of a standardized recipe for the minced and pureed carrot raisin salad does not indicate use of a thickener.

Interview with FSS confirmed that the cook added more thickener to the recipe of the above mentioned food item and it was too sticky which may affect the taste, nutritive value, appearance and food quality. [s. 72. (3) (a)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.

Interview with the president of the Residents' Council confirmed that he/she does not remember that the Residents' Council reviewed the meal and snack times.

Interview with the director of support services confirmed that the home does not have any documents to support the review of meal and snack times with the Residents' Council. [s. 73. (1) 2.]

2. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, providing residents with any eating aids and/or assistive devices required to safely eat and drink as comfortably and independently as possible.

Observations made on an identified date, in an identified dining room revealed that residents #026 and #027 were not provided assistive feeding devices respectively.

A review of the plans of care revealed that the above mentioned residents require assistive feeding devices respectively.

Interview with a PSW confirmed that the above mentioned residents are provided with regular feeding devices at all meals.

Interview with the dietary aide confirmed that the residents were not provided with the required assistive devices for meals.

Interview with the FSS confirmed that the dietary aide should follow the plan of care and provide the required assistive devices to the above mentioned residents. [s. 73. (1) 9.]

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,

(a) the Residents’ Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home’s mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home’s policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home’s procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home’s policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm’s length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)
(o) information about the Residents’ Council, including any information that may be provided by the Residents’ Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that

may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The licensee has failed to ensure that the admission package includes the home’s policy to promote zero tolerance of abuse and neglect of residents.

Review of the admission process checklist and interview with the ED confirmed that the home’s policy to promote zero tolerance of abuse and neglect of residents is not included within the admission package. [s. 78. (2) (c)]

2. The licensee has failed to ensure that the admission package includes an explanation of the duty to make mandatory reports related to incidents resulting in harm or risk of harm.

Review of the admission process checklist and interview with the ED confirmed that the admission package does not include an explanation of the duty to make mandatory reports related to incidents resulting in harm or risk of harm to residents. [s. 78. (2) (d)]

3. The licensee has failed to ensure that the admission package includes the home's policy on minimizing the restraining of residents and how to obtain a copy of the policy.

Review of the admission process checklist and interview with the ED confirmed that the admission package does not include the home's policy on minimizing the restraining of residents and how to obtain a copy of the policy. [s. 78. (2) (g)]

4. The licensee has failed to ensure that the admission package includes an explanation of whistle-blowing protections related to retaliation.

Review of the admission process checklist and interview with the ED confirmed that the admission package does not include an explanation of whistle-blowing protections related to retaliation. [s. 78. (2) (q)]

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents’ Council, if any, in developing and carrying out the survey, and in acting on its results.

Interview with the President of the Residents' Council confirmed that the Residents' Council does not have any input in developing and carrying out the satisfaction surveys and in acting on its results.

Interview with the ED confirmed that the home did not seek advice of the Residents' Council in developing and carrying out the satisfaction survey and in acting on its results. [s. 85. (3)]

2. The licensee has failed to ensure that the results of the survey are documented and made available to the Residents’ Council, if any, to seek their advice under subsection (3).

Interview with the President of the Residents' Council confirmed that the he/she does not remember if the results of the satisfaction surveys were available to the Residents' Council.

Interview with the ED confirmed that the results of the satisfaction surveys were not made available to the Residents' Council. [s. 85. (4) (a)]

WN #22: 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 :

1. The licensee has failed to ensure that the written policies and protocols for the medication management system are reviewed and 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 interview with the acting DOC confirmed that the policies of the medication management system are solely developed and approved by the licensee's pharmacy service provider. [s. 114. (3) (b)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of the medical advisory committee records and interviews with the acting DOC and ED confirmed that the ED is not a member of the interdisciplinary team which evaluates the medication management system. [s. 115. (1)]

WN #24: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, 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.

Record review and interviews held with the ED and the acting DOC confirmed that the medication management system is not evaluated on an annual basis. [s. 116. (1)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
1. The resident's ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1). O. Reg. 79/10, s. 224 (1).

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
4. The method to apply to the Director for a reduction in the charge for basic accommodation and the supporting documentation that may be required, including the resident's Notice of Assessment issued under the Income Tax Act (Canada) for the resident's most recent taxation year. O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the admission package includes information on the ability to retain a physician or RN (EC) to perform the required services.

Review of the admission process checklist and interview with the ED confirmed that the admission package does not include information on the ability to retain a physician or RN (EC) to perform the required services. [s. 224. (1) 1.]

2. The licensee has failed to ensure that the admission package includes how to apply for a reduction in the charge for basic accommodation, and the supporting documentation required, e.g. the most recent Notice of Assessment issued under the Income Tax Act.

Review of the admission process checklist and interview with the ED confirmed that the admission package does not include how to apply for a reduction in the charge for basic accommodation, and the supporting documentation required, e.g. the most recent Notice of Assessment issued under the Income Tax Act. [s. 224. (1) 4.]

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Record review of the minutes of the Professional Advisory Clinic (PAC) for 2013, and interviews with the DOC, infection prevention nurse and the executive director confirmed the program was not evaluated and updated at least annually in accordance with subsection 86 (1) of the Act. [s. 229. (2) (d)]

Issued on this 9th day of January, 2015

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

Original report signed by the inspector.

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SARAN DANIEL-DODD (116), NICOLE RANGER (189), NITAL SHETH (500), VALERIE PIMENTEL (557)
Inspection No. / No de l'inspection :	2014_378116_0014
Log No. / Registre no:	T-132-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 5, 2015
Licensee / Titulaire de permis :	INA GRAFTON GAGE HOME OF TORONTO 40 Bell Estate Road, SCARBOROUGH, ON, M1L-0E2
LTC Home / Foyer de SLD :	INA GRAFTON GAGE HOME 40 Bell Estate Road, SCARBOROUGH, ON, M1L-0E2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Rob Bissonnette

To INA GRAFTON GAGE HOME OF TORONTO, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;
(e) continence care products are not used as an alternative to providing assistance to a person to toilet;
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the following requirements are in compliance relating to continence care of all residents in the home:
- provide a range of continence care products that is to be available and accessible to residents and staff at all times.
- all residents who require continence care products have sufficient changes to remain clean, dry and comfortable
- all residents are provided with a range of continence care products that, are based on their individual assessed needs and properly fit the residents.

The plan shall outline staff roles and responsibilities to identify, communicate and rectify situations regarding continence care products.

The plan shall be submitted to Saran.DanielDodd@ontario.ca on or before January 15, 2015.

Grounds / Motifs :

1. Written communication was provided to the inspector by an identified staff member where, on an identified date, the acting DOC was notified that there were only medium size briefs available for the residents.
Response received from the acting DOC indicated that briefs are delivered on a specified weekday. The registered staff member informed the inspector that due to the response being received the day after the stock was delivered residents that required large briefs were provided with medium briefs until the following continence care delivery. [s. 51. (2) (f)]

(116)

2. The written plan of care for resident #023 identifies that the resident is frequently incontinent of urine and requires medium incontinence brief to be clean and comfortable.

Interviews held with registered staff and PSW's confirmed that during a specified period, continence care products were not available within the home which resulted in resident #023 not receiving the required continence brief changes. Registered staff members and PSW's communicated to the inspector that residents were observed to be left in soaked continence products when coming on for an identified shift. [s. 51. (2) (f)]

(116)

3. Staff interviews revealed that there were insufficient continence care products available for residents at all times. Staff reported to the inspector that there are multiple times where there are no continence care products available for residents and the staff are forced to use liners in-between the resident continence product in order to keep the residents dry.

Staff members reported to the inspector that they were informed by management that due to funding they are provided one continence brief per shift per resident. PSWs reported to the inspector that they brought this issue to the management's attention during a staff meeting. Staff reported that this is still an ongoing issue in the home. [s. 51. (2) (f)] (189)

4. The licensee has failed to ensure that there is a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes.

Review of the health record for resident #042 revealed that on a specified date, an identified PSW observed the clothing and bed sheets of resident #042 to be wet and soiled with urine.

Interviews held with registered staff and personal support workers (PSW) confirmed that there have been multiple occasions where continence care products were not available upon the unit and within the home to provide residents with sufficient changes to remain dry and comfortable. [s. 51. (2) (f)] (116)

5. Review of the health record for resident #023 revealed that on an identified date, during a specified shift, resident #023 complained to a registered staff member that he/she was calling for help and no one attended to him/her. The resident was observed by the PSW and registered staff to be soaking wet with stool and urine.

Interviews held with the acting DOC and associate director of care (ADOC) confirmed that there were errors in the count for continence care products which resulted in inadequate amounts being available to provide sufficient changes to residents to remain clean, dry and comfortable. [s. 51. (2) (g)]

(116)

6. Review of the health record for resident #042 revealed that on a specified date, at the commencement of an identified shift, an identified PSW observed the clothing and bed sheets of resident #042 to be wet and soiled with urine.

Interviews held with registered staff and PSW's confirmed that there have been multiple occasions where continence care products were not available upon the unit and within the home to provide residents with sufficient changes to remain dry and comfortable. [s. 51. (2) (g)]
(116)

7. The licensee has failed to ensure that the resident who requires continence care products have sufficient changes to remain clean, dry and comfortable.

An interview with an identified PSW revealed that on an identified date, resident #051 did not have sufficient changes to remain clean, dry and comfortable. Staff reported that resident #051 requires frequent changes of his/her continence product. The PSW indicated that because there were not enough continence care products available for the resident, the PSW had to leave the resident with a wet diaper during a specified shift.

Record review indicated that resident #051 is on a toileting schedule and is to be checked every two hours per shift for incontinence.

An interview with an identified PSW revealed that on an identified date, he/she did not have assistance to change four identified residents who required continence care. The PSW revealed that because he/she was alone on the unit and did not have assistance to change the four residents, the residents were left with wet briefs during the shift. [s. 51. (2) (g)]

(189)

8. The licensee has failed to ensure that residents provided with a range of continence care products based on their individual assessed needs.

Resident #022 is identified as being incontinent of urine and requires medium size brief.

During an interview with the Power of Attorney (POA) of resident #022, it was reported that the improper size of continence briefs are being provided to the resident which is resulting in his/her clothing being wet and soiled with urine. The concerns were brought to the attention of the charge nurse and ED who agreed to have the resident re-measured in order to meet his/her individual assessed needs. The home was unable to provide any documentation or confirmation of reassessment of brief sizing for resident #022.

An interview held with the ADOC confirmed that a range of continence care products are not available based on individual based needs and the home is following a directive put in place by the previous DOC whereby, only medium and extra large briefs are ordered. [s. 51. (2) (h) (i)]
(116)

9. The licensee has failed to ensure that residents are provided with a range of continence care products that properly fit the residents.

Through review of the home's continence products inventory and interviews held with staff it was revealed that the home only provides two sizes of brief.

Interview held with the ADOC confirmed that a directive was put in place by the former DOC for the removal of small briefs and to only order medium and extra large brief. The ADOC confirmed that the current continent products available do not provide a range of continence care products that properly fit the residents which results in leakage. [s. 51. (2) (h) (ii)]
(116)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 30, 2015

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2014_357101_0016, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that there is a system in place to ensure all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they are not being supervised by staff.

The plan shall outline staff roles and responsibilities to identify, communicate and respond to situations involving doors that cannot be kept closed and locked.

The plan shall be submitted to Saran.DanielDodd@ontario.ca on or before January 15, 2015.

Grounds / Motifs :

1. The following area of non compliance was identified on June 16, 2014 during inspection# 2014_357101_0016 where an order was issued and remains outstanding as of this inspection.

The licensee failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors kept closed and locked when they are not being supervised by staff.

During the initial home tour, the inspector observed the doors leading to the server area of the kitchen located on an identified unit did not lock. The first door into the back hallway did not have a lock on the door, the second door that leads into the back entrance of the server vestibule area was ajar from the door frame, it did not close and was not able to be locked. The back door entrance into the server had a key pad on the door that allowed access into the server area, the key pad did not function and did not lock the door.

Interviews with the ESM and acting ED confirmed that the doors and locks leading to non-residential areas did not function properly and that residents could access these areas unsupervised. [s. 9. (1) 2.] (557)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 15, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(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
(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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the following requirements are in compliance relating to the staffing plan:
- provide for a staffing mix that is consistent with residents' assessed care and safety needs
- promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
- 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

Please submit the compliance plan to Saran.DanielDodd@ontario.ca no later than January 15, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that the staffing plan provides a staffing mix that is consistent with residents' assessed care and safety needs.

For a specified period, the staffing level on an identified shift decreased by one PSW. The home has four floors with 32 residents per floor. There is one PSW per floor and two float PSWs that are assigned to float between two floors.

Interviews held with PSWs that work various shifts indicated that there is insufficient staff to meet the residents' needs on the specified shift. The PSWs reported there were multiple incidents where a second PSW was not available to assist the assigned PSW and residents did not receive continence care to remain clean and dry.

Staff interviews revealed that on the specified shift, there are a number of residents who require monitoring for wandering and behavioural issues and residents who require two- person assistance for toileting and care. Staff reported in addition to these resident care tasks, they are also required to respond to call bells, complete point of care documentation and additional tasks such as cleaning residents` wheelchairs.

Staff reported that the residents' situated on the heaviest unit in the home require higher care assistance. Staff reported that, as per job routine for the specified shift, the float PSW is required to assist on the unit for one hour for the first round, and then return to assist with the second round for another hour. Staff report that this is an insufficient amount of time to assist the residents who required two person assistance or monitoring, and they are unable to complete their assigned work before moving on to assist the other unit.

Two identified PSWs reported to the inspector that on two identified occasions on the night shift, they were left alone on the unit to care for 32 residents. Interview with the staffing coordinator revealed that over a specified five-month period, there were two shifts where a PSW called in sick and the shift and was not filled according to the current staffing plan.

A critical incident report was submitted to the Director stating that on a specified date, two identified residents were found soaking wet by both their POA's. The POA's had informed the staff of this occurrence. Interview with the identified PSW revealed that during rounds, the float PSW came to the floor and started to assist the PSW with care on the identified unit, but was unable to finish with care for the residents on the opposing unit as the designated hour was completed and the float PSW had to return to the other floor to assist with care. The PSW reported that there were four residents on the opposing unit who required two

person assistance for continence care but did not receive it as there was not a second person to assist the PSW. Record review for the four identified residents confirmed that each resident required two person assistance for toileting.

An identified registered staff member reported to the inspector that the current staffing on an identified shift does not meet the needs of residents as the residents on an identified unit are unpredictable with their wandering and behaviours and an identified unit is heavy care requiring two person staffed at all times on the floor. The registered staff reported that safety is a concern for the residents as the PSWs leave the floor unattended to clean the wheelchairs at the back of the unit.

The acting ED reported in an interview with the inspector that the current staffing plan for the specified shift was based on an assessment of the financial labour distribution in the home.

The ADOC and acting ED reported that a staffing assessment was conducted by the previous Chief Nursing Officer, but they were unable to provide documentation to support this statement. [s. 31. (3)]

2. The licensee has failed to ensure that there is a written record of each annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The ED for the home was unable to provide the inspector with a written record of the annual evaluation of the staffing plan for the home. [s. 31. (4)] (189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 30, 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 5th day of January, 2015

Signature of Inspector / Signature de l'inspecteur :

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

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