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 prévue le Loi de 2007 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
Direction de l'amélioration de la performance et de la conformité

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Feb 01, 2016;	2015_344586_0023 (A1)	032713-15	Resident Quality Inspection

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

THE WENLEIGH
2065 Leanne Boulevard MISSISSAUGA ON L5K 2L6

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

JESSICA PALADINO (586) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Extension made to CO#002 compliance date.

Issued on this 1 day of February 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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JESSICA PALADINO (586) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 26, 27, 30, December 1, 2, 3, 4, 8, 9, 10, 11, 14, 15, 16 and 17, 2015.

The following Complaint and Critical Incident Inspections were completed concurrently with the RQI:

004264-14, 008694-14, 008696-14, 003116-15, 003650-15, 003755-15, 003282-15, 004121-15, 006359-15, 006630-15, 011157-15, 011715-15, 012794-15, 016360-15, 017305-15, 018798-15, 019023-15, 020390-15, 027578-15, 030278-15, 032352-15, 032517-15, 006242-14, 008339-14, 033851-15 and 034275-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, Environmental Supervisor, Resident Services Director of Care (RS-DOC), Clinical Director of Care (C-DOC), Assistant Director of Care (A-DOC), RAI Co-ordinator, Family Community Co-ordinator, Program and Support Services Manager, Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aids, Housekeeping staff, residents, and family members.

During the course of this inspection, inspectors toured the building (resident rooms, common spaces including dining rooms, tub/shower areas, the kitchen and serveries); reviewed health records, policies and procedures, menus, maintenance logs, and housekeeping audits; observed care, residents, and staff.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

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

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

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

19 WN(s)
7 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 LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were protected from abuse by anyone and not neglected by the licensee or staff.

A) On an identified date in February 2015, resident #052 was the victim of abuse by

PSW #012 during care. The written statement of staff member #011, who observed the abuse, revealed the resident was in pain during transfer and asked for the care to stop. The investigation by the Administrator confirmed the resident had expressed pain during transfers on several occasions and PSW #012 confirmed this was not reported to the nursing staff for re-assessment. The PSW did not stop and modify the care.

Two days later, the same resident was observed by the same staff member. The same PSW was roughly repositioning the resident in their chair. The witness identified this was done roughly. The resident confirmed they were treated roughly. (169)

B) On an identified date in March 2015, resident #054's family member informed the home of a situation the resident reported to them regarding PSW #004 calling the resident names on two separate occasions, as well as being rough during care when putting the resident to bed. Review of the home's internal investigation notes and interview with the RC-DOC confirmed that the verbal abuse did occur. Resident #054 was not protected from verbal abuse by staff member #004.

C) On an identified date in April 2015, resident #055 reported to the home that PSW #005 tried to hurt the resident, but the resident defended themselves. The resident was visibly upset by the incident for several days. Review of the home's internal investigation notes and interview with the RC-DOC confirmed that the abuse did occur. Resident #055 was not protected from abuse by staff member #004.

D) On an identified date in July 2015, resident #014 was found in their room in their wheelchair by PSW #005 after having just vomited, and the PSW took the resident's soiled clothing off and left to provide care to another resident before returning a short while after. The home's internal investigation notes confirmed that the resident was left alone by PSW #005 when they were at a high risk of choking, and while the resident was very upset. The home's investigation concluded the resident was neglected as they felt they were left alone and the care the resident required was not provided. This was confirmed by the RS-DOC. Resident #014 was not protected from neglect by PSW #005.

E)On an identified date in October 2015, resident #054's family member witnessed resident #017 sliding down in their wheelchair, at which time PSW #005 raised their voice at the resident to stop sliding, and roughly grabbed the resident by their shoulders to pull them up. Review of the home's internal investigation notes and

interview with the RS-DOC confirmed that the staff member was verbally and physically abusive to resident #017, and the resident was not protected from abuse by PSW #005. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The following housekeeping concerns were noted throughout the home during the course of the inspection:
i) On November 26, 2015 the resident chairs located in the hallways on Orchard Terrace were observed to be heavily soiled with spills on them and with chipped wood and chair arms. On December 3, 2015 the chairs were observed again and noted to be in the same unclean condition.
ii) The dining furniture on all three floors was observed to be unclean on November 26, 2015. There was food debris observed on the table legs and chairs throughout

the dining areas. The carts used by the dietary staff within the servery were observed to be soiled with heavy food debris and in poor condition. This was verified by observation of inspectors throughout the review and management.
iii) The pull strings for the over bed lighting was absent in two of the nine rooms observed. Where the string was in place, it was noted to be soiled with brown debris in three rooms. The call bell cords in several washrooms was noted to be of a cloth material and had brown debris on it. Both strings were not able to be cleaned and sanitized. [s. 15. (2) (a)]

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

The following maintenance concerns were noted throughout the home during the course of the inspection:
i) The flooring material in the following bedrooms had a seam running the length of the room that was split, with a gap; #218, 233, 234 and 352. The flooring material in bedroom #322 was bubbling and lifting at the far left corner. The tile flooring in the far right elevator was badly cracked.
ii) The toilets in bathrooms #211, 219 and 301 were stained yellow, and the toilets in bathrooms #203, 204, 220, 238, 252 and 250 had cracked and missing caulking around the bases, as well as some rusting and brown discolouration.
iii) The ceiling tiles in room #316B had significant water damage, resulting in several large dark down spots. There were also stained ceiling tiles noted in the hallways throughout the home.
iv) Large pieces of the baseboard were missing in rooms #144 and 305.
v) The bannister in the hallway outside of room #122 was loose and coming off of the wall.
vi) The overhead lighting strings above the resident's beds in bedrooms #103 and 115 were missing.
vii) There was a large rust ring on the bathroom counter in room #320.
viii) Several areas throughout the home were noted to have wall damage. The walls were scraped with chunks of drywall missing, exposing the metal corner bead in some cases, in rooms #203, 207, 211, 234, 245 and 346.
ix) The kitchenettes in the home's common areas had broken cabinets and drawers, chunks missing from the support beams, and rust around the sinks. [s. 15. (2) (c)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented for cleaning of the home, including, i. resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and ii. common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

On November 26, December 2 and December 3, 2015, the following were observed throughout the home:
Flooring in resident rooms was observed to be in need of a deep cleaning, with areas of flooring darker in colour with a build up of debris observed. Flooring was also observed to be coming apart at the seams in the middle of the walking area of resident rooms. Some rooms were observed with duct tape on the seams from door to windows. In one room, there was two strips of tape. Carpets on all three floors in the hallways was observed to be soiled and in poor repair in sections. Wall surfaces in all dining areas was observed to have food debris on them where the soiled dishes are scraped of food. Toilet bowls with raised toilet seats were observed throughout the home to be soiled with urine and feces, when the raised toilet seat was removed. One room was observed on three separate days to have the same "dust bunnies" under the bed and had not been cleaned. This was confirmed with the management team. [s. 87. (2) (a)]

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 O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On November 27, 2015, the call bell in an identified resident's room was observed to be taped at the plate against the wall so the de-activation button was activated at all times. The call bell was activated at the end of the call cord and the call bell was not functional. The RPN confirmed the call bell was not functional. [s. 17. (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 the home is equipped with a resident-staff communication and response system that is easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the home's abuse policy was complied with.

A) The home's abuse policy "Resident Abuse – Abuse Prevention Program – Whistle-Blowing Protection" (policy number LTC-CA-ALL-110-05-02, last revised October 9, 2014) directed staff to report any abuse, suspected abuse or allegation of abuse immediately to their respective supervisor. As per the home's internal investigation notes, on an identified date in April 2015, resident #055 reported to housekeeping staff #008 and PSW #010 that a staff member had been mean to them and tried to hurt them. PSW #010 reported this to RPN #009 who said they would document the incident. This allegation of abuse by resident #055 was not documented and not reported to the home until the following day by RPN #007. An internal 'Resident and Family Comment/Concern Form' was completed by the RPN that day and received by the management of the home the day after that, when the incident was then submitted to the Director. Interview with the RS-DOC confirmed this. The staff did not report alleged abuse immediately and did not comply with the home's abuse policy.

B) On an identified date in February 2015, staff member #011 observed possible physical abuse toward resident #052. The staff member did not report the allegation of abuse immediately and reported it two days later, when the staff member observed the same PSW being abusive toward the same resident. This was confirmed by the Administrator and the Critical Incident Report. (169) [s. 20. (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 the home's abuse policy is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that resident #052 was transferred safely.

On an identified date in February 2015, resident #052 was transferred to the washroom by PSW #012 using a specific type of lift. The resident was observed by staff member #011 to be in pain as they were not in the toilet lift correctly or comfortably. The resident reported to the PSW that it was very painful. This was confirmed by the written documentation and interviews with Administrator. [s. 36.]

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 resident #052 and every resident is transferred safely, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) According to health records, resident #042 had multiple areas of altered skin integrity that required treatment since admission. Health records indicated that weekly reassessments of these areas had not been completed over a six month period. The A-DOC confirmed this, stating that it was the home's expectation that weekly skin reassessments be completed for residents with altered skin integrity until the areas were resolved.

B) Resident #047 was noted to have ongoing pressure areas that healed and became opened. Review of health records indicated that weekly skin assessments had not been completed on at least four occasions during the following nine weeks. The week after this period, the pressure areas were noted to have worsened. According to the A-DOC, the home's expectation was that registered staff conduct weekly skin assessments until a wound was healed. The A-DOC confirmed that weekly skin assessments had not been conducted for resident #047 according to the home's policy.

C) Resident #022 was identified as having two areas of altered skin integrity that required treatment. Review of their health record indicated that the home had not conducted weekly skin assessments of these areas to identify if the treatment had been effective or when the areas were resolved. The C-DOC confirmed this. [s. 50. (2) (b) (iv)]

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 all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #8: 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. (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; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

A) Resident #041's Minimum Data Set (MDS) Assessments from two quarterly assessments in 2015 indicated that the resident had a deterioration of their bladder continence status. During interview, the RAI Co-ordinator stated that the home's expectation was that continence assessments should be completed on admission and when continence deteriorated. They confirmed that continence assessments had not been completed for resident #001 when their status changed. (586)

B) According to health records, resident #042 was occasionally incontinent of bladder upon admission and continent of bowels. The resident's bladder and bowel continence worsened between admission and an identified date in 2015. The resident had a history of altered skin integrity in the brief area, and urinary tract infections. Health records revealed that bladder and bowel continence had not been assessed on admission or when the resident's continence worsened.

During interview, the A-DOC stated that the home's expectation was that continence assessments should be completed on admission and when continence deteriorated. They confirmed that continence assessments had not been completed for resident #042 in order to identify causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was not conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence on admission or when their continence deteriorated. [s. 51. (2) (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 each resident that is incontinent receives an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident required, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances are labelled properly and kept inaccessible to residents at all times.

On November 26, 2015, dining areas on all three floors were observed to be accessible. Doors to the dining areas were unlocked or ajar allowing residents to enter freely. Upon entering the dining areas, the serveries were also accessible with the swing doors ajar, allowing residents to go into the servery freely. There were no staff observed in the dining or servery areas. Within each servery, there was hazardous chemicals accessible within unlocked cabinets. A chemical named Oasis, with a Drug Identification Number, was observed and accessible. This was confirmed by staff on each home area. [s. 91.]

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 all hazardous substances are labelled properly and kept inaccessible to residents at all times, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) Resident #022 was noted to have a wound and was examined by an external physician. The resident was prescribed a dosage of a particular medication three times per day for five days on an identified date in 2015, and a written prescription was sent to the home. Review of the medication administration record indicated that the resident was administered 300 milligrams less than the prescribed amount over the five days. During interview, the RS-DOC confirmed that resident #022 had not received a drug in accordance with the directions specified by the prescriber.

B) Resident #045's health record indicated that they developed a pressure ulcer infection and had signs of dehydration. According to progress notes and their electronic medical record, the resident was prescribed a particular therapy for three days; treatment was initiated at 1900 hours on an identified date in 2015. Progress notes indicated that the medication was stopped at 0700 three days later due to staff in the home not being able to find the appropriate solution for infusion. The medication was stopped 12 hours before the medication was scheduled to be discontinued, leading to the resident not receiving 600 milliliters of the therapy. During interview, registered staff and the C-DOC confirmed that the resident's fluid intake was below their requirement during the time when they should have received the infusion. The C-DOC confirmed that the medication had not been administered as prescribed. [s. 131. (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 all drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007, 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that sets out, (a) the planned care for the resident.

A) On an identified date in December 2015, resident #017 was observed in the dining room during breakfast using a specific PASD device on their wheelchair. The resident was later observed in the hallway without the PASD applied. PSW #003 confirmed that the resident only required the use of the PASD during meals. The document that the home referred to as the care plan, and the kardex used by the PSWs to direct care, did not include identification of the use of the PASD during meals as indicated through observation by the inspector and confirmation by staff.

B) During Stage 1 interview on an identified date in November 2015, resident #012 indicated that they enjoyed their food hot, so they had requested specific interventions to ensure their food was kept hot; however, the dietary staff did not always do this, which in turn caused the resident to go without eating. Interview with the resident's family member on an identified date in December 2015, confirmed these same concerns. Review of the resident's progress notes revealed that on three occasions in the past year, the resident complained of this intervention not being followed and thus their food being cold. The resident diet list kept in the servery, which staff refer to during service, and the documented care plan did not include the specific interventions. The resident's written plan of care did not include planned care for the resident regarding their dietary needs and preferences. [s. 6. (1) (a)]

2. The licensee failed to ensure that the resident's substitute-decision maker (SDM) was given the opportunity to participate fully in the development and implementation of resident #006's plan of care.

On November 9, 2015, RPN #006 identified resident #056's hand to be swollen and notified the Nurse Practitioner who came to assess the resident. The resident's SDM voiced concern to the home that they were not notified of this information until they discovered the swelling themselves when visiting the resident the following day. Review of the resident's health care record confirmed the SDM was not notified of the resident's swollen hand. Interview with the RS-DOC and Administrator confirmed this, and confirmed RPN #006 should have notified the resident's SDM immediately. Resident #056's SDM was not given the opportunity to participate fully in the implementation of resident #006's plan of care. [s. 6. (5)]

WN #12: 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 failed to ensure that the home's falls policy was not complied with.

The home's policy "Resident Safety and Risk Management – Resident Falls" (policy number LTC-CA-WQ-200-07-08, last revised November 2014) indicated that when a resident experienced a fall, staff were to complete a Post Fall Analysis in Point Click Care (PCC). Resident #011, who was at a high risk for falls, experienced an unwitnessed fall on an identified date in 2015, and a review of their clinical record confirmed a Post Fall Analysis was not completed. This was confirmed by the RC-DOC. [s. 8. (1) (b)]

WN #13: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's vision.

A) Review of resident #042's admission assessment indicated that the resident had impaired vision and required the use of eyeglasses. Their health records indicated that they had a condition that limited vision and required treatment. Their MDS assessment completed on an identified date in 2015, indicated that they had moderately impaired vision, and did not use glasses. The associated Resident Assessment Protocol Summary (RAPS) indicated that the resident required the use of large print and wore eyeglasses for reading.

During interview, the resident stated that they could not see very well; therefore, they could not see name tags of staff, the clock or read. The resident was not wearing glasses at the time. Review of progress notes indicated that the resident had discussed their frustration with their loss of vision on at least two occasions during in 2015. They and their family member had complained to the home earlier in 2015, that the resident often did not know who was providing their care and staff would not always tell them their names; this made them feel anxious.

Review of the most recent document the home referred to as resident #042's care plan directed staff to ensure the path was clear and that eyeglasses were not in use. Additional direction regarding management of resident's independence and needs regarding their impaired vision had not been included. During interview the RS-DOC confirmed that resident #042's plan of care was not based on an interdisciplinary assessment of the resident's vision, and that their needs were not being met.

B) Resident #014's health record identified a the resident had impaired vision. During an interview on an identified date in November 2015, the resident indicated that the staff come into their room and begin providing care without saying who they were or what they were there to do, requiring the resident to ask these questions, which upsets the resident. Interview with PSW #001 confirmed that if a part-time staff member or someone the resident did not know came in to their room, they should be introducing themselves to the resident. Review of the resident's documented care plan did not include this intervention, therefore resident #014's plan of care was not based on an interdisciplinary assessment of the resident's vision, and that their needs were not being met. (586) [s. 26. (3) 4.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure that a resident was dressed appropriately in accordance with their preferences.

During interview, resident #042 and their family stated that a PSW providing continence care during a night shift re-dressed the resident so that their pajamas were positioned below the resident's knees. The home's investigative notes confirmed this. During interview, the RS-DOC stated that dressing a resident so that their pajama bottoms were positioned in this way was not according to the resident's preferences and posed a safety risk to the resident. [s. 40.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated: (1) a change of 5 per cent of body weight, or more, over one month.

Resident #001 was at a moderate nutritional risk and experienced significant weight loss in one month in 2015. A dietary referral was sent to the RD on an identified date in 2015, in which their response note indicated that they would request a re-weigh of the resident and would follow-up the next time they were in the home. The resident continued to lose further weight the following two months, during which time two more dietary referrals were made to the RD for weight loss. The resident was not re-assessed by the RD until two months after the initial referral, during their quarterly review, in which time a nutritional supplement was implemented to mitigate the weight loss. This was confirmed by the RD. [s. 69. 1.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that linens such as pillows were maintained in a good state of repair and free from stains.

All three floors were randomly inspected and pillows were observed by the inspectors on December 2, 2015. Fifteen rooms were inspected and two rooms were noted to have severely cracked pillows and another two pillows were observed to have brown stains. [s. 89. (1) (c)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

On an identified date in February 2015, resident #052 was the victim of abuse by PSW #012 during care. The written statement of staff member #011, who observed the abuse, revealed the resident was being transferred and was in pain. The investigation by the Administrator confirmed the resident had expressed pain during transfers on several occasions and PSW #012 confirmed this was not reported to the nursing staff for re-assessment. The PSW did not stop and modify the care.

Two days later, the same resident was observed by the same staff member. The same PSW was re-positioning the resident in their wheelchair. The witness identified this was done roughly. The resident confirmed they were treated roughly. The two incidences were reported to the home that day.

The Critical Incident Report was not submitted to the Director until 13 days after the second incident was reported to home. This was confirmed by the Administrator. [s. 104. (2)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The licensee failed to ensure that there was no more than a three-month supply of drugs obtained for use in the home.

On December 16, 2015, the government stock supply room was inspected by Inspector #536. The following was noted:
i. Twenty nine bottles of Senekot-1000 tablets per bottle
ii. Thirty-five bottles of Cascara
iii. Twenty-six bottles of Koffex
iv. Twenty-one bottles of Milk of Magnesia
v. Thirty-two bottles of Apo K-100 tablets per bottle
vi. Twenty bottles of Micro-K-100 tablets per bottle

The A-DOC who was responsible for ordering the government stock confirmed that most of these medications exceeded a three-month supply. [s. 124.]

WN #19: 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 failed to ensure that drugs complied with the manufacturer’s instructions.

On December 16, 2015, the weekend emergency stock area was inspected for expired medications. The inspector noted that there were six fleet enemas on the shelf. All six enemas had an expiration date of August 2014. This was confirmed by the C-DOC. [s. 129. (1) (a)]

Issued on this 1 day of February 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JESSICA PALADINO (586) - (A1)

Inspection No. / No de l'inspection : 2015_344586_0023 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 032713-15 (A1)

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

Report Date(s) / Date(s) du Rapport : Feb 01, 2016;(A1)

Licensee / Titulaire de permis :

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

LTC Home / Foyer de SLD :

THE WENLEIGH
2065 Leanne Boulevard, MISSISSAUGA, ON, L5K-2L6

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Peter Puiatti

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To Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure that all residents including residents #017, #014, #054, #055 and #052 are protected from abuse and neglect. The home is to review and revise as appropriate their Abuse Policy, as well as provide education to all staff on the abuse policy and their requirements under the legislation, with the program including definitions of abuse including verbal, emotional and physical abuse, residents rights, lifts and transferring techniques, following the plan of care, mandatory reporting of abuse, and documentation of relevant information where indicated. The home is also to evaluate each incident of abuse and neglect quarterly and annually, document this evaluation, make recommendations as needed, implement the recommendations and evaluate the effectiveness of the home's strategies to prevent abuse and neglect.

Grounds / Motifs :

1. The licensee failed to ensure that all residents were protected from abuse by anyone and not neglected by the licensee or staff.

On an identified date in February 2015, resident #052 was the victim of abuse by PSW #012 during care. The written statement of staff member #011, who observed the abuse, revealed the resident was in pain during transfer and asked for the care to stop. The investigation by the Administrator confirmed the resident had expressed pain during transfers on several occasions and PSW #012 confirmed this was not reported to the nursing staff for re-assessment. The PSW did not stop and modify the care.

Two days later, the same resident was observed by the same staff member. The same PSW was roughly repositioning the resident in their chair. The witness identified this was done roughly. The resident confirmed they were treated roughly. (169)

2. On an identified date in October 2015, resident #054's family member witnessed resident #017 sliding down in their wheelchair, at which time PSW #005 raised their voice at the resident to stop sliding, and roughly grabbed the resident by their shoulders to pull them up. Review of the home's internal investigation notes and interview with the RS-DOC confirmed that the staff member was verbally and physically abusive to resident #017, and the resident was not protected from abuse by PSW #005. (586)

3. On an identified date in July 2015, resident #014 was found in their room in their wheelchair by PSW #005 after having just vomited, and the PSW took the resident's soiled clothing off and left to provide care to another resident before returning a short while after. The home's internal investigation notes confirmed that the resident was left alone by PSW #005 when they were at a high risk of choking, and while the resident was very upset. The home's investigation concluded the resident was neglected as they felt they were left alone and the care the resident required was not provided. This was confirmed by the RS-DOC. Resident #014 was not protected from neglect by PSW #005. (586)

4. On an identified date in April 2015, resident #055 reported to the home that PSW #005 tried to hurt the resident, but the resident defended themselves. The resident was visibly upset by the incident for several days. Review of the home's internal investigation notes and interview with the RC-DOC confirmed that the abuse did occur. Resident #055 was not protected from abuse by staff member #004. (586)

5. On an identified date in March 2015, resident #054's family member informed the home of a situation the resident reported to them regarding PSW #004 calling the resident names on two separate occasions, as well as being rough during care when putting the resident to bed. Review of the home's internal investigation notes and interview with the RC-DOC confirmed that the verbal abuse did occur. Resident #054 was not protected from verbal abuse by staff member #004. (586)

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

Feb 29, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure the chairs in the hallways, the dining furniture (including tables and chairs) and serving carts, and the over bed lighting pull strings and washroom call bell cords are thoroughly cleaned, and kept clean and sanitary.

The licensee shall also ensure the resident bedroom flooring is free of cracks and gaps, bathroom toilets are free of stains, cracks, rust and missing caulking, bedroom and hallway ceiling tiles are free of water damage and discolouration, missing baseboards are replaced, hallway bannisters are secure, overhead light strings are replaced, damaged walls are repaired, and common area kitchenettes are repaired, and to ensure the home, furnishings, and equipment are maintained in a safe condition and in a good state of repair.

Grounds / Motifs :

1. Previously issued as a VPC in September 2014.

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

The following housekeeping concerns were noted throughout the home during the course of the
inspection:
i) On November 26, 2015 the resident chairs located in the hallways on Orchard Terrace were
observed to be heavily soiled with spills on them and with chipped wood and chair arms. On
December 3, 2015 the chairs were observed again and noted to be in the same unclean condition.
ii) The dining furniture on all three floors was observed to be unclean on November 26, 2015. There was food debris observed on the table legs and chairs throughout the dining areas. The carts used by the dietary staff within the servery were observed to be soiled with heavy food debris and in poor condition. This was verified by observation of inspectors throughout the review and management.
iii) The pull strings for the over bed lighting was absent in two of the nine rooms observed. Where the string was in place, it was noted to be soiled with brown debris in three rooms. The call bell cords in several washrooms was noted to be of a cloth material and had brown debris on it. Both strings were not able to be cleaned and sanitized. (169)

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

The following maintenance concerns were noted throughout the home during the course of the
inspection:
i) The flooring material in the following bedrooms had a seam running the length of the room that
was split, with a gap; #218, 233, 234 and 352. The flooring material in bedroom #322 was bubbling and lifting at the far left corner. The tile flooring in the far right elevator was badly cracked.
ii) The toilets in bathrooms #211, 219 and 301 were stained yellow, and the toilets in bathrooms
#203, 204, 220, 238, 252 and 250 had cracked and missing caulking around the bases, as well as some rusting and brown discolouration.
iii) The ceiling tiles in room #316B had significant water damage, resulting in several large dark down spots. There were also stained ceiling tiles noted in the hallways throughout the home.
iv) Large pieces of the baseboard were missing in rooms #144 and 305.
v) The bannister in the hallway outside of room #122 was loose and coming off of the wall.
vi) The overhead lighting strings above the resident's beds in bedrooms #103 and 115 were missing.
vii) There was a large rust ring on the bathroom counter in room #320.
viii) Several areas throughout the home were noted to have wall damage. The walls were scraped
with chunks of drywall missing, exposing the metal corner bead in some cases, in rooms #203, 207, 211, 234, 245 and 346.
ix) The kitchenettes in the home's common areas had broken cabinets and drawers, chunks missing from the support beams, and rust around the sinks. (586)

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

Apr 30, 2016(A1)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

The licensee shall deep clean resident bedroom flooring and hallway carpeting, and thoroughly clean dining room walls, toilet bowls with raised toilet seats and beneath resident beds.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Grounds / Motifs :

1. The licensee failed to ensure that procedures were implemented for cleaning of the home,
including, i. resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact
surfaces and wall surfaces, and ii. common areas and staff areas, including floors, carpets,
furnishings, contact surfaces and wall surfaces.

On November 26, December 2 and December 3, 2015, the following were observed throughout the home:
Flooring in resident rooms was observed to be in need of a deep cleaning, with areas of flooring
darker in colour with a build up of debris observed. Flooring was also observed to be coming apart at the seams in the middle of the walking area of resident rooms. Some rooms were observed with duct tape on the seams from door to windows. In one room, there was two strips of tape. Carpets on all three floors in the hallways was observed to be soiled and in poor repair in sections. Wall surfaces in all dining areas was observed to have food debris on them where the soiled dishes are scraped of food. Toilet bowls with raised toilet seats were observed throughout the home to be soiled with urine and feces, when the raised toilet seat was removed. One room was observed on three separate days to have the same "dust bunnies" under the bed and had not been cleaned. This was confirmed with the management team. (169)

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

Jan 31, 2016

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

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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
Toronto ON M5S 2B1
Télécopieur : 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 1 day of February 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JESSICA PALADINO - (A1)

Service Area Office /
Bureau régional de services : Hamilton