Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 31, 2017;	2017_560632_0013 (A1)	012996-17	Resident Quality Inspection

Licensee/Titulaire de permis

ALBRIGHT GARDENS HOMES INC.
5050 Hillside Drive Beamsville ON L0R 1B2

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

Albright Gardens Homes, Incorporated
5050 Hillside Drive Beamsville ON L0R 1B2

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

YULIYA FEDOTOVA (632) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Licensee request for extension of compliance date for compliance order #003.

Issued on this 31 day of October 2017 (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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YULIYA FEDOTOVA (632) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): June 28, 29, July 4, 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 2017

The following inspections were completed concurrently with the Resident Quality Inspection.

Critical Incident System Report:

012818-16-related to: Prevention of Abuse and Neglect

030130-16-related to: Prevention of Abuse and Neglect, Personal Support Services-Care

032420-16-related to: Prevention of Abuse and Neglect, Personal Support Services-Care

032494-16-related to: Prevention of Abuse and Neglect, Personal Support Services-Care

006758-16-related to: Falls Prevention

027451-16-related to: Falls Prevention

027878-16-related to: Falls Prevention, Minimizing of Restraints

021412-16-related to: Responsive Behavior

008878-16-related to: Critical Incident Response

014535-16-related to: Hospitalization and Change in Condition

018533-16-related to: Critical Incident Response, Medication

009894-17-related to: Prevention of Abuse and Neglect, Personal Support Services-Care

010346-17-related to: Responsive Behaviors

007022-17-related to: Prevention of Abuse and Neglect, Personal Support Services-Care

014405-17- related to: Prevention of Abuse and Neglect

005475-17-related to: Falls Prevention

007966-17-related to: Falls Prevention

Inquiries:

013588-17-related to: Family Council

003807-17-related to: Falls Prevention

002126-17-related to: Sufficient Staffing

005995-17-related to: Infection Prevention and Control

Complaints:

030095-16-related to: Personal Support Services

026662-16-related to: Nutrition and Hydration

014172-17-related to: Prevention of Abuse and Neglect

011717-17-related to: Prevention of Abuse and Neglect

005978-17-related to: Falls Prevention, Personal Support Services, Skin and Wound Care, Reporting and Complaints, Accommodation Services-Housekeeping

Follow Ups:

004560-17-related to: Falls Prevention

During the course of the inspection, the inspector(s) spoke with Chief Executive Officer (CEO), Chief Nursing Officer (CNO), Director of Nursing and Residents' Care (DONRC), Pharmacist, Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Director of Dietary Services (DDS), Restorative Care Coordinator, Resident Assessment Instrument (RAI) Co-ordinator, Back-up RAI Co-ordinator Staff Educator, Nursing Secretary, Dietary Aid (DA), with residents and their families.

During the course of the inspection, the inspector(s) conducted a tour of the home, including resident rooms and common areas, reviewed infection prevention and control, housekeeping, maintenance, reviewed documentation and relevant clinical records, reviewed relevant policies, procedures, and practices within the home, reviewed meeting minutes, investigation notes, staff files, observed the provision of care, medication administration, and meal service.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Critical Incident Response

Falls Prevention

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

- **22 WN(s)**
- **11 VPC(s)**
- **5 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 49. (2)	CO #001	2017_569508_0002	632

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. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

1. Resident #026's family member complained that their family member did not always get their bath or shower. A review of resident #026's written plan of care indicated that this resident was to receive a bath or shower during the evening shift on two identified dates of each week. Point of Care (POC) was reviewed as it related to bathing for resident #026.

According to the follow up question report found on the home's electronic medical record, resident #026 did not receive a bath or shower twice per week on four occasions on identified dates between April and June, 2017. The task response indicated "Not Applicable" by staff #298 on an identified date in April, 2017 and by staff #250 on identified dates in May, and June, 2017. During interviews, staff #298 and #250 confirmed that they had missed some of resident #026's baths/showers and that they were not able to make up the baths with a different method of bathing or on a different day. They stated that when there were only two staff members assigned to care for 30 residents during the evening shift, it was difficult for them to get the evening baths completed. They stated that they were instructed to indicate "Not Applicable" if they were unable to complete a bath/shower. They stated that they did not offer resident #026 an alternative since they had no time.

Please note: this area of non compliance was identified during a complaint inspection, log #005978-17, conducted concurrently during this Resident Quality Inspection. (526)

2. A review was completed of ten random residents for baths received during the four week cycle on identified dates in June, 2017. The following was identified:

i) A review of resident #053's written plan of care indicated that this resident was to receive a bath on two specific dates each week. POC was reviewed as it related to bathing for resident #053. During a four week review, this resident was to have received eight baths. According to the follow up question report for this resident, they received a total of six baths during this period of time.

ii) A review of resident #054's written plan of care indicated that this resident was to receive a bath on two specific dates each week. POC was reviewed as it related to bathing for resident #054. During a four week review, this resident was to have received eight baths. According to the follow up question report for this resident, they received a total of four baths during this period of time and refused one bath.

iii) A review of resident #055's written plan of care indicated that this resident was to receive a bath on two specific dates each week. POC was reviewed as it related to bathing for resident #055. During a four week review, this resident was to have received eight baths. According to the follow up question report for this resident, they received a total of three baths during this period of time, refused two baths and one response was documented as not applicable.

iv) A review of resident #056's written plan of care indicated that this resident was to receive a bath on two specific dates each week. POC was reviewed as it related to bathing for resident #056. During a four week review, this resident was to have received eight baths. According to the follow up question report for this resident, they received a total of five baths during this period of time. Three responses were documented as not applicable.

v) A review of resident #057's written plan of care indicated that this resident was to receive a bath on two specific dates each week. POC was reviewed as it related to bathing for resident #057. During a four week review, this resident was to have received eight baths. According to the follow up question report for this resident, they received a total of four baths during this period of time. One response was documented as not applicable.

vi) A review of resident #058's written plan of care indicated that this resident was

to receive a bath on two specific dates each week. POC was reviewed as it related to bathing for resident #058. During a four week review, this resident was to have received eight baths. According to the follow up question report for this resident, they received a total of four baths during this period of time. Two responses were documented as not applicable.

vii) A review of resident #059's written plan of care indicated that this resident was to receive a bath on two specific dates each week. POC was reviewed as it related to bathing for resident #059. During a four week review, this resident was to have of received eight baths. According to the follow up question report for this resident, they received a total of three baths during this period of time.

viii) A review of resident #060's written plan of care indicated that this resident was to receive a bath on two specific dates each week. POC was reviewed as it related to bathing for resident #060. During a four week review, this resident was to have received eight baths. According to the follow up question report for this resident, they received a total of two baths during this period of time.

ix) A review of resident #061's written plan of care indicated that this resident was to receive a bath on two specific dates each week. POC was reviewed as it related to bathing for resident #061. During a four week review, this resident was to have received eight baths. According to the follow up question report for this resident, they received a total of five baths during this period of time.

x) A review of resident #062's written plan of care indicated that this resident was to receive a bath on two specific dates each week. POC was reviewed as it related to bathing for resident #062. During a four week review, this resident was to have received eight baths. According to the follow up question report for this resident, they received a total of five baths during this period of time.

When interviewed staff #235, #269 and #181 acknowledged that "not applicable" meant short staffed. The RAI Co-ordinator confirmed that no signature meant no bath had occurred. During a review of the staffing schedules for June 1 to 28, 2017 with the nursing secretary, it was also noted that 25 missed baths occurred when the home had full staffing and 13 missed baths occurred when the home was short staffing. The inspection identified a total of 38 missed baths out of 80 potential baths for ten residents in a four week period which equaled 48 percent (%) of baths in a four week period being missed. This was confirmed by the RAI Co-ordinator. (536) [s. 33. (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 O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that
(a) all medication incidents and adverse drug reactions were documented,

reviewed and analyzed
(b) corrective action was taken as necessary, and
(c) a written record was kept of everything required under clauses (a) and (b).

A) According to interviews with the Pharmacist and DONRC, the home's process for destruction of controlled substances involved registered staff co-signing count sheets for a given medication. They would then deposit the medications to be discarded along with the count sheet into the slot of a double locked medication box located in a treatment room on the second, third, fourth and fifth floors. Together, the Pharmacist and staff #206 would remove the contents of the boxes, ensure the count was accurate, destroy and dispose of the denatured medications for pick up from a secured area in the home by a vendor.

According to the Critical Incident System (CIS), on March 24, 2016, the home reported that controlled substances were missing/unaccounted for from the surplus medication box located on the fifth floor as of March 23, 2016. During interview with the home's RAI Co-odinator and review of notes provided by the home, the following controlled substances were observed to be missing by staff #206 and the Pharmacist who were counting controlled substances that had been discarded and were to be destroyed:

i) 55 tablets of Percocet tablets contained within two (2) cards discarded on January 3 and 5, 2016; and
ii) 22 tablets Ativan 0.5 milligram (mg) discarded on November 12, 2015.

According to CIS #C501-000002-16, police were not notified initially since "there are no suspects at this time"; police were notified after a telephone call with an inspector related to the Critical Incident report submitted by the home. The home's Pharmacist confirmed that the fifth floor medication box had not been emptied between October 8, 2015 and March 23, 2016. The Pharmacist and DONRC stated that it was determined that the slots on the boxes were large enough to enable the removal of medications from the box after they had been deposited there for destruction. According to the DONRC, the Restorative Care Coordinator and staff #275, all registered staff and restorative care PSWs had access to the treatment rooms that contained the narcotic drop boxes for an unspecified time prior to June 17, 2016. The Pharmacist indicated that they had been in the home on May 6, 2016 and on that day made a request to a vendor that four (4) industry standard double locked boxes be delivered to the home. These arrived in the home on May 10, 2016 but were not installed until June 17, 2016.

RAI Co-ordinator, the DONRC, Pharmacist, and the CEO could not confirm whether any staff had been interviewed in relation to the incident, the extent of the review and analysis, or if there had been any response to prevent a similar incident from occurring other than the arrival of new boxes to the home . The home could not provide any documentation of the review, analysis, responses or implementation of these responses to this incident.

According to CIS C501-000008-17, on June 17, 2017, the Pharmacist and staff #206 discovered additional controlled substances that had gone missing from the fifth floor drop box as follows:

i) 30.5 tablets Ativan 0.5mg, put in box on April 21, 2016
ii) 30 tablets of Ativan 1 mg, put in box on May 25, 2016
iii) 26.5 tablets of Ativan .5mg, put in box on June 1, 2016
iv) 28 tablets of Dialudid 1 mg, put in box on June 9, 2016

According to interviews with the Pharmacist, they had not been asked to empty and destroy the contents of the fifth floor box since March 23, 2016, when the previous incident was identified. They indicated that there was no regular schedule for the destruction of controlled substances in the home. According to the CEO, DONRC, and the RAI Co-ordinator, steps were taken to prevent further incidents after June 17, 2017, including assigning keys for each treatment room only to registered staff on their respective floors; removing materials from treatment rooms so that restorative PSWs would not have access to the area where discarded controlled substances were located, and installation of the boxes that had been in the home since May 10, 2016; these new boxes had a smaller drop slot, a metal deterrent bar and a larger capacity. The Pharmacist was to come to the home for drug destruction more frequently however did not empty and destroy the contents of the fifth floor box with a registered staff until October 23, 2016. There have been no further missing or unaccounted for controlled substances from drop boxes since June 17, 2016.

During an interview, the CEO indicated that they were not aware if corrective action had taken place to prevent additional controlled substances from going missing or unaccounted for after March 23, 2016, and that the documentation of any investigation, review and analysis of the incident that occurred on March 23, 2016, including a police record could not be provided.

Please note: this area of non compliance was identified during a Critical Incident (CI) inspection, log #008878-16, conducted concurrently during this RQI.

B) Review of the home's Medication Incident Notification system revealed that, on an identified date in April, 2017, during the shift change between evenings and nights, staff #157 was notified that the controlled substance count was inaccurate on the fifth floor north wing. Upon inspection, they noted the back of resident #050's medication card had been cut on medication pocket #23, so that one half tablet of pain management medication was missing. The count was 29 one half tablets when it should have been 30 one half tablets. The incident report revealed that the medication was unaccounted for after they searched the medication storage areas.

During interview, staff #157 stated that they misplaced photocopies taken of the count sheet and damaged medication card; they also stated that they were unable to complete the incident report using the home's electronic medication incident notification system until their next shift on May 3, 2017. Interview with the DONRC revealed that they had not been involved with this incident, that the incident report did not include a review, analysis or corrective actions that might have been implemented. They stated that they could not locate any notes about a review, analysis or corrective actions to prevent this incident from occurring again.

C) According to the home's Medication Incident Notification System the home had four (4) medication incidents reported in April 2017, three (3) reported in May 2017, and six (6) reported in June 2017. Of these 13 incidents, 11 involved residents. Review of the documentation provided by the home during this inspection could not confirm that these incidents had been reviewed or analyzed, or that corrective action was taken except in one incident where a staff person had been disciplined. During interview, the Pharmacist stated that they were not involved in review and analysis of medication incidents involving nursing actions. During interview, the DONRC stated that they were periodically involved in responding to medication incidents by speaking with staff, however, they did not maintain notes. They were not aware if corrective action had been taken in relation to these medication incidents.

During an interview, the CEO stated that the CNO was not in the home and would investigate medication incidents. The CEO confirmed that documents to support the review and analysis of these incidents along with corrective action, if any, could not be found. [s. 135. (2)]

2. The licensee failed to ensure that,
(a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions,
(b) any changes and improvements identified in the review were implemented, and
(c) a written record was kept of everything provided for in clause (a) and (b).

Review of minutes for the home's Pharmacy and Therapeutics Committee seven (7) meetings that took place on February 4, June 2, August 4, October 4, and December 8, 2016, and February 9, and June 8, 2017, revealed that review of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review had not been completed during at least five of these meetings and were not documented during any of these meetings. Discussion and review of changes and improvements were not documented except that a shift count audit should be completed during the June 2, 2016, meeting, and that registered staff had received an education session during the August 4, 2016 meeting. During an interview, the Pharmacist stated that they provided a brief descriptive tally of monthly medication incidents that occurred in the home. They stated that a review and analysis, recommendations and implementation were not discussed during the home's Pharmacy and Therapeutics meetings or at any other time on a quarterly basis. During interview, the RAI Co-ordinator who was tasked with taking the meeting minutes confirmed this as well. [s. 135. (3)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 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 residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

O. Reg. 79/10 defines "abuse" in r. 2. (1) for the purposes of the definition of "abuse" in subsection 2 (1) of the Act,

"emotional abuse" means,

(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or

(b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences; ("mauvais traitement d'ordre affectif")

"physical abuse" means, subject to subsection (2),

(a) the use of physical force by anyone other than a resident that causes physical injury or pain,

(b) administering or withholding a drug for an inappropriate purpose, or

(c) the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitement d'ordre physique")

"verbal abuse" means,

(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or

(b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences. ("mauvais traitement d'ordre verbal") O. Reg. 79/10, s. 2 (1).

(2) For the purposes of clause (a) of the definition of "physical abuse" in subsection (1), physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances. O. Reg. 79/10, s. 2 (2).

O. Reg. 79/10, s. 5. defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

1. The plan of care for resident #032 revealed they had a loss of intellectual capacity and were at risk for falls and skin impairment and required a mechanical device for all transfers.

On an identified date in April, 2016, the home submitted CI C501-000004-16, reporting that on an identified date in April, 2016, the resident was found unattended in their bathroom by the afternoon shift. The home's investigation concluded that the resident had been unattended. The skin assessment completed by registered staff after being removed from the toilet revealed they developed some altered skin integrity.

On an identified date in June, 2017, the CNO acknowledged that the policy titled "Resident Lifting Policy, N-10.9" revised September 2010, stated two staff must be present when using the mechanical devices. The CNO also stated that while the resident was in their bathroom, at least one staff should have remained with the resident.

The CNO acknowledged that on an identified date in April, 2016, resident #032 was neglected when staff #100 provided assistance to the resident and left them

unattended.

Staff #100 received discipline for their neglect of resident #032.

Please note: this non compliance was issued as a result of CI log #012818-16, which was conducted concurrently with the RQI. (130)

2. The plan of care for resident #023 revealed they had a loss of intellectual capacity, difficulty in swallowing and required a mechanical device for all transfers. On an identified date in October, 2016, the home submitted Critical Incident C501-000017-16, reporting that on an identified date in October, 2016, the resident was found unattended in their bathroom by the afternoon shift. The home's investigation concluded that the resident had been unattended in their bathroom. The clinical health record indicated that resident #023 developed altered skin integrity as a result of being left unattended for an extended period of time.

On July 5, 2017, the CNO acknowledged that the policy titled "Resident Lifting Policy, N-10.9" revised September 2010, stated that two staff must be present when using the mechanical device. The CNO also stated that while the resident was in their bathroom, at least one staff should have remained with the resident.

The CNO acknowledged that on an identified date in October, 2016, resident #023 was neglected when staff #371 provided assistance to the resident and left them unattended.

Staff #371 was counselled for their neglect of resident #023.

Please note: this non-compliance was issued as a result of CI log # 030130-16, which was conducted concurrently with the RQI. (611)

3. The plan of care for resident #038 revealed they had a loss of intellectual capacity and required a mechanical device for all transfers.
On an identified date in November, 2016, the home submitted Critical Incident C501-000021-16, reporting that on an identified date in November, 2016, the resident was found unattended in a mechanical device, outside of the resident's room. The home's investigation concluded that resident #038 may have pushed the mechanical device from the washroom to outside the resident room, as this resident was in the area when found by staff. As a result of this incident, resident #038 developed altered skin integrity.

On July 7, 2017, the CNO acknowledged that the policy titled "Resident Lifting Policy, N-10.9" revised September 2010, stated at least one staff should have remained with the resident.

The CNO acknowledged that on an identified date in November, 2016, resident #038 was neglected when staff #178 left this resident in a mechanical device unattended.

Please note: this non-compliance was issued as a result of CI log # 032420-16 and log #032494-16, which was conducted concurrently with the RQI. (611)

4. The plan of care for resident #030 revealed they had a loss of intellectual capacity, difficulty in swallowing and required a mechanical device for all transfers assisted by two staff. On an identified date in May, 2017, the home submitted a Critical Incident C501-000013-17, reporting that on an identified date in May, 2017, the resident was found in their bathroom unattended in a mechanical device used for transfers. The home's investigation concluded that the resident had been unattended in their bathroom, however, the investigation was inconclusive as all the staff working that shift denied provided assistance to the resident. The clinical health record indicated that resident #030 developed altered skin integrity as a result of being left unattended. On July 7, 2017, the CNO acknowledged that the policy titled: Resident Lifting, policy number: N-10.9, last revised: September 2010, stated at least one staff should have remained with the resident. The CNO acknowledged that on an identified date in May, 2017, that resident #030 was neglected when proved assistance to the resident and left them unattended.

Please note: this non-compliance was issued as a result of CI log #009894-17, which was conducted concurrently with the RQI. (536)

5. On an identified date in July, 2017, staff #112 was providing care to resident #063 in their room. Staff #159 was in the hallway outside of the room, and heard staff #112 speaking in a loud tone to resident #063. This resident was witnessed to have refused the provision of care at that time and was disappointed. Staff #112 was witnessed to ask the resident a question in a humiliating manner. Staff #112 then began to intimidate the resident. Staff #112 was described as being verbally abusive with resident #063 during this incident. Upon witnessing the incident, staff #159 intervened, provided emotional support to resident #063, and requested that staff #112 leave the room.

The home conducted an investigation regarding this incident, and disciplinary action took place as a result of the incident.
In an interview conducted with the CNO, it was acknowledged that resident #063 was not protected from abuse.

Please note: this non-compliance was issued as a result of CI log # 014405-17, which was conducted concurrently with the RQI . (611)

6. On an identified date in April, 2017, the home submitted a Critical Incident C501-000008-17 for abuse/neglect, reporting that on an identified date in April, 2017, the SDM of resident #028 reported an incident that had occurred earlier in the day.

The home's investigation concluded that staff #373 forcefully transferred resident #028 from their bed to their mobility device. This resident was provided physical assistance by staff #373 and during this incident, the resident sustained some injuries.

The plan of care for resident #028 at the time of the incident, indicated that this resident was to be transferred by two staff members with the use of a mechanical device.

On an identified date in April, 2017, resident #028 expressed being upset and frightened about this incident that occurred on an identified date in April, 2017.
The CNO acknowledged that on an identified date in April, 2017, resident #028 was not protected from abuse. Staff #373 was disciplined as a result of this incident.

Please note: this non-compliance was issued as a result of CI log #007022-17, which was conducted concurrently with the RQI. (611) [s. 19. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 003

WN #4: 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 staff used safe transferring and positioning devices or techniques when assisting residents.

1. On an identified date in April, 2016, the home submitted CI C501-000004-16, reporting that on an identified date in April, 2016, the resident was found unattended in their bathroom by the afternoon shift. The home's investigation concluded that the resident had been unattended in their bathroom.

The home's policy titled "Resident Lifting Policy, N-10.9" revised September 2010, stated that two staff must be present, when using a mechanical device.

The plan of care for resident #032 revealed they had a loss of intellectual capacity and were at risk for falls and skin condition and required a mechanical device for all transfers.

The CNO confirmed that on an identified date in April, 2016, staff #100 did not use safe transferring technique, when resident #032 was transferred using the mechanical device and left unattended.

Please note: this non compliance was issued as a result of CI log #012818-16,

which was conducted concurrently with the RQI. (130).

2. On an identified date in October, 2016, the home submitted Critical Incident C501-000017-16, reporting that on an identified date in October, 2016, resident #023 was found unattended in their bathroom by the afternoon shift. The home's investigation concluded that the resident had been unattended in their bathroom.

The home's policy titled "Resident Lifting Policy, N-10.9" revised September 2010, stated two staff must be present when using a mechanical device.

The plan of care for resident #023 revealed they had a loss of intellectual capacity and required a mechanical device for all transfers.
The CNO confirmed that on an identified date in October, 2016, staff #371 did not use safe transferring techniques, when resident #023 was transferred in their bathroom using a mechanical device and left this resident unattended.

Please note: this non-compliance was issued as a result of CI Log #030130-16, which was conducted concurrently with the RQI. (611)

3. The plan of care for resident #038 revealed they had a loss of intellectual capacity and required a mechanical device for all transfers.

The home submitted Critical Incident C501-000021-16, reporting that on an identified date in November, 2016, the resident was found unattended in a mechanical device outside of a resident room.

The home's investigation concluded that resident #038 may have pushed the mechanical device from the washroom to outside the resident room, as this resident was in the area when found by staff. As a result of this incident, resident #038 developed an altered skin integrity.

On July 7, 2017, the CNO acknowledged that the policy titled "Resident Lifting Policy, N-10.9" revised September 2010, stated at least one staff should have remained with the resident.

The CNO acknowledged, that on an identified date in November, 2016, staff #178 did not use safe transferring techniques when resident #038 was transferred in their bathroom using a mechanical device and left this resident unattended.

Please note: this non-compliance was issued as a result of CI log # 032420-16 and log #032494-16, which was conducted concurrently with the RQI. (611)

4. The plan of care for resident #031 revealed they had a loss of intellectual capacity, difficulty in swallowing and required a mechanical device for all transfers assisted by two staff. On an identified date in May, 2017, the home submitted a Critical Incident C501-000013-17, reporting that on an identified date in May, 2017, the resident was found unattended in their bathroom by the day shift. The home's investigation concluded that the resident had been unattended. As a result of this incident, resident #031 developed altered skin integrity. On an identified date in July, 2017, the CNO acknowledged that the policy titled: Resident Lifting, policy number: N-10.9, last revised: September 2010, stated at least one staff should have remained with the resident. The CNO also acknowledged, staff did not use safe transferring techniques, when resident #031 was transferred in their bathroom using a mechanical device and left the resident unattended.

Please note: this non-compliance was issued as a result of CI log #009894-17, which was conducted concurrently with the RQI. (536)

5. On an identified date in April, 2017, the home submitted Critical Incident C501-000008-17, reporting that on an identified date in April, 2017, the SDM of resident #028 reported an incident that had occurred earlier in the day.

The home's investigation concluded that staff #373 forcefully transferred resident #028 from their bed to their mobility device. This resident was physically lifted by staff #373, and during this incident, the resident sustained some injuries.

The plan of care for resident #028 at the time of the incident, indicated that this resident was to be transferred by two staff members with the use of a mechanical device.

The CNO acknowledged that on an identified date in April, 2017, staff #373 did not use safe transferring techniques when resident #028 was forcefully transferred to their mobility device.

Please note: this non-compliance was issued as a result of CI log #007022-17, which was conducted concurrently with the RQI. (611) [s. 36.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act and in accordance with r. 68. (2) (a), which included development and implementation in consultation with a registered dietitian who was a member of the staff of the home, of policies and procedures relating to nutrition care and dietary service and hydration, and r. 68. (2)(e), which required that the program include a weight monitoring system to measure and record the weight and height.

1. The home's "Dietary Policy and Procedural Manual: Height and Weight Monitoring D – 1.26" (revised December 2016) indicated that the Unit Supervisor would verify by re-weighing resident if any weight change of (+/-) two kilograms (kg) or more from the previous month occurred, which would be completed within

24 hours. On an identified date in July, 2017, review of resident #004's weight history contained information about weight changes from the previous months: April and May in 2017. During this period of time, the resident's significant weight changes were not verified. On an identified date in July, 2017, staff #329 indicated that the registered staff requested in the home re-weighing of residents with significant weight changes, which was confirmed by the Registered Dietitian (RD). The home's staff did not comply with the home's "Dietary Policy and Procedural Manual: Height and Weight Monitoring". (632)

2. The home's "Dietary Policy and Procedural Manual: Height and Weight Monitoring D – 1.26" (revised December 2016) indicated that the Unit Supervisor would verify by re-weighing resident if any weight change of (+/-) two kg or more from the previous month occurred, which would be completed within 24 hours. On an identified date in July, 2017, review of resident #008's weight history contained information about weight changes from the previous months: March and April in 2017. During this period of time, the resident's significant weight changes were not verified. On an identified date in July, 2017, staff #329 indicated that the registered staff requested in the home re-weighing of residents with significant weight changes, which was confirmed by the RD. The home's staff did not comply with the home's "Dietary Policy and Procedural Manual: Height and Weight Monitoring". (632)

3. The home's "Dietary Policy and Procedural Manual: Height and Weight Monitoring D – 1.26" (revised December 2016) indicated that the Unit Supervisor would verify by re-weighing resident if any weight change of (+/-) two kg or more from the previous month occurred, which would be completed within 24 hours. On an identified date in July, 2017, review of resident #016's weight history contained information about weight changes from the month of May in 2017. During this period of time, the resident's significant weight changes were not verified. On an identified date in July, 2017, staff #329 indicated that the registered staff requested in the home re-weighing of residents with significant weight changes, which was confirmed by the RD. The home's staff did not comply with the home's "Dietary Policy and Procedural Manual: Height and Weight Monitoring". [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act and in

accordance with r. 48 required the home to develop and implement a falls prevention and management program.

A review of a CIS submitted by the home and progress notes indicated that on an identified date in April, 2017, resident #029 had an unwitnessed fall with an injury. Review of clinical records indicated that head injury routine was initiated several hours later by the home's staff. Review of "Falls Prevention Management Program N – 9.5.6" revised April, 2017, contained the information about initiation of head injury routine as a part of a post fall assessment. Review of "Head Injury Routine Policy N - 9.6.1" revised March, 2012, stated that it was to be initiated by RN or RPN for a total of 72 hours post fall for each resident, who had unwitnessed fall, a witnessed fall with a possible head injury and who was on anti-coagulant therapy. On an identified date in July, 2017, an interview with DONPS indicated that head injury routine was not initiated post fall as a part of full head-to-toe post-fall assessment and was completed several hours later. The home's staff did not comply with the home's "Falls Prevention Management Program" and "Head Injury Routine Policy N - 9.6.1", which was a part of "Falls Prevention and Management Program".

Please note: this non-compliance was issued as a result of CI log #007966-17, which was conducted concurrently with the RQI. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

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

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).

Findings/Faits saillants :

1. The licensee failed to ensure that a written plan of care for each resident set out clear directions to staff and others who provided direct care to the resident.

1. A review of a Complaint submitted by the family to the home indicated that resident #037 was on an identified diet and on identified dietary restrictions. Review resident #037's plan of care indicated that the resident was to be provided specific drinks. On an identified date in July, 2017, the resident's meal observation indicated that they received regular drink for their meal. On an identified date in July, 2017, interview with staff #358 indicated that the home did not provide specific drinks for residents except different specified drinks, which was confirmed by the DDS on the same day. The home did not set out clear directions to staff and others who provided direct care to resident #037.

Please note this non-compliance was issued as a result of Complaint Log #026662 -16, which was conducted concurrently with the RQI. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

1. Review of MDS assessment records (lock date was on an identified date in June, 2017) contained information on providing extensive assistance to resident #016 with one staff. A review of resident #016's plan of care (was last reviewed on an identified date in June, 2017) contained no information about ADL support to be provided for eating. On an identified date in July, 2017, staff #128 indicated that the resident required extensive assistance for eating. On an identified date in July, 2017, RAI Co-ordinator acknowledged that the care set out in the plan of care for resident #016 contained no ADL assistance for eating that was based on the most recent MDS assessment.

2. A review of a CIS submitted by the home and progress notes indicated that on an identified date in February, 2016, the resident #034 had a fall and sustained an injury. A review of a resident #034's plan of care (last reviewed on an identified date in March, 2016) indicated that the resident required total assistance for mobility by two staff. Review of MDS assessment records (was locked on an identified date in April, 2016) indicated that the resident required supervision with one staff for mobility. On an identified date in July, 2017, MDS Co-ordinator acknowledged that the care set out in the plan of care was not based on an assessment of the resident.

Please note this non-compliance was issued as a result of CI Log #006758-16, which was conducted concurrently with the RQI.

3. A review of a CIS submitted by the home and progress notes indicated that on an identified date in September, 2016, the resident #036 had a fall and sustained an injury. Review of MDS assessment records (was locked on an identified date in August, 2016) indicated that the resident required extensive assistance with one person for transfers. A review of resident #036's plan of care (was last reviewed on an identified date in August, 2016 and closed on an identified date in September, 2016) indicated that the resident required one-two staff assistance for transfers with no information about the level of ADL self-performance. On an identified date in July, 2017, MDS Co-ordinator acknowledged that the care set out in the plan of care for resident #036 was not based on MDS assessment.

Please note this non-compliance was issued as a result of CI Log #027451-16, which was conducted concurrently with the RQI. [s. 6. (2)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

1. Resident #034 had a fall and sustained an injury on an identified date in February, 2016, and was assessed to be at risk for falls. The plan of care dated as last reviewed on May 24, 2017, indicated that the resident had a device as falls' prevention strategy. On an identified date in July, 2017, the resident was observed and the device was not properly applied. Interview with staff # 260 and #293 indicated that device was to be applied in an identified manner. On an identified date in July, 2107, an interview with the CNO and RAI Co-ordinator acknowledged that that the care set out in the plan of care for resident #034 was not provided to the resident as specified in their plan.

Please note: this non-compliance was issued as a result of CI log #006758-16, which was conducted concurrently with the RQI. (632)

2. A review of a complaint submitted by the family to the home indicated that services were not provided for resident #037 with the diagnosis of chronic condition. Review of the resident's plan of care (was last reviewed on an identified date in March, 2017) indicated the nourishment to be provided at afternoon as specialized snack. Review of the Nourishment Serving Report indicated that no information was included about providing the nourishment at the afternoon nourishment for resident #037. On an identified date in July, 2017, interviewed staff #358, who indicated that staff referred to the Nourishment Serving Report (was reviewed on an identified date in June, 2017), when serving nourishments from snack cart to residents. On an identified date in July, 2017, DDS confirmed that the care set out in the plan of care was not provided to resident #037 as specified in the plan.

Please note: this non-compliance was issued as a result of complaint log #026662-16, which was conducted concurrently with the RQI. [s. 6. (7)]

4. The licensee failed to ensure that the staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

1. A review of a complaint submitted by the family to the home indicated that nutrition services were not provided for resident #037 with the diagnosis of chronic

condition. Review of the resident's plan of care (last reviewed on an identified date in March, 2017) contained directions to provide an identified dietary restriction for the resident. On an identified date in July, 2017, interview with staff #358 indicated that staff referred to the Meal Assistance Legend (review date was on an identified date in June, 2017), stored in servery, when serving food to residents. Review of the Meal Assistance Legend for the resident indicated directions for the staff to refer to posted identified document. On an identified date in July, 2017, interviewed staff #358, who indicated that the identified document was not posted in the servery, which was confirmed by the DDS on an identified date in July, 2107. The home did not provide convenient and immediate access to the information used as a reference by staff, when providing food services for the resident, who required an identified dietary restriction.

Please note: this non-compliance was issued as a result of complaint log #026662-16, which was conducted concurrently with the RQI. (632)

2. On an identified date in July, 2017, nourishment cart distribution was observed in one of the home's area. The nourishment cart did not contain "Nourishment Serving Report", which had names of residents, diet, texture, morning, afternoon and evening beverages and snacks. On an identified date in July, 2017, staff #149 was interviewed and indicated that there was no "Nourishment Serving Report" on the cart. Review of "Dietary Policy and Procedures Manual – Provision of Snacks D -2.7" (implemented date: December 2016) contained information about Snack Delivery List (i.e. Nourishment Serving Report) that must accompany the snack delivery cart to serve as a source of information for the staff serving snacks and drinks to residents. On an identified date in July, 2017, interview with DDS indicated that the "Nourishment Serving Report" was to be available on the nourishment cart. Staff did not have convenient and immediate access to the "Nourishment Serving Report" while delivering morning drinks for residents. [s. 6. (8)]

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 and ensuring that (1) (c) a written plan of care for each resident set out clear directions to staff and others who provide direct care to the resident, (2) the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, (7) the care set out in the plan of care is provided to the resident as specified in the plan, and (8) 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, to be implemented voluntarily.

WN #7: 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, (e) was available in every area accessible by residents.

During the initial tour of the home on June 28, 2017, the Long Term Care (LTC) Inspector revealed that each of the home's 14 balconies located on the second, third, fourth and fifth floor, as well as the two centre courtyards located on the second floor did not have a resident-staff communication and response system located in those outside areas. All of the balconies and courtyards had the resident staff communication and response system located inside the doors of the home. The CEO, when interviewed, acknowledged that all of the communication and response systems were located inside the home. [s. 17. (1) (e)]

2. The licensee failed to ensure that the resident-staff communication and response system uses sound to alert staff, and is calibrated so that the level of sound is audible to staff.

A complaint was received at the Ministry of Health and Long Term Care (MOHLTC), identifying that call bells when activated could not be heard in the dining room. The LTC Inspector did a tour of all dining rooms at mealtimes, and rang a call bell before entering each dining room. When the LTC Inspector entered any of the dining rooms the call bells were audible however, as the LTC Inspector walked towards the serveries in each of the dining rooms the call bells became less audible if there was any talking, or cleaning of dishes at the servery end of the dining room. The CEO when interviewed, identified that the registered staff carry a phone and the call bells ring to those phones, so the call bells would be heard in the dining rooms during meal service. During interview with registered staff #179 and #348 it was identified that the call bells only ring to the stationary phone at the desk, not to the portable phones they carry. The LTC Inspector confirmed this on each unit. During interview, PSW's #235 and #281 each acknowledged that in the past, the call bells used to ring to the phones that they carried however, they no longer were in use. The PSWs also acknowledged, that during dining service when the meal was in full service the call bells are almost inaudible unless the room was totally quiet. The home did not ensure that the communication and response system was audible in the dining rooms to staff.

Please note: this non compliance was issued as a result of complaint log #030095-16, which was conducted concurrently with the RQI. [s. 17. (1) (g)]

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 and ensuring that the home is equipped with a resident-staff communication and response system that, (e) is available in every area accessible by residents and that, (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, to be implemented voluntarily.

WN #8: 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 that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy titled: "Zero Tolerance of Neglect and Abuse", last revised: May 2011, stated: Procedure for Mandatory Reporting to the Director - MOHLTC- section 24(1) of the LTCHA states that a person who had reasonable grounds to suspect that any of the following has occurred or might occur shall immediately report the suspicion and the information upon which it is based to the Director. Improper or incompetent treatment or care of a resident that results in harm or a risk of harm to the resident, abuse of a resident by anyone or neglect of a resident by the licensee or staff that results in harm or a risk of harm to a resident. On an identified date in June, 2017, the family of resident #031 brought forth an allegation of alleged sexual abuse. On an identified date in July, 2017, the CNO acknowledged that a CIS had not been submitted to the Director. The home did not comply with their "Zero Tolerance of Neglect and Abuse" policy in regards to immediately reporting an allegation of abuse of a resident by anyone.

Please note: this non compliance was issued as a result of complaint log #011717-17, which was conducted concurrently with the RQI. [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 and ensuring that the policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that was reported to the licensee, was immediately investigated and any requirements that were provided for in the regulations for investigating and responding as required under clauses (a) and (b) were complied with. 2007, c. 8, s. 23 (1).

On an identified date in June, 2017, the family member of resident #031 brought forth an allegation that the resident had voiced to a visiting companion earlier in the day, and again in the evening to them, that a staff member had sexually abused them. The resident, when interviewed by a registered nurse the same evening, stated that the staff member sexually abused them.
According to interview notes dated on an identified date in June, 2017, when interviewed by the CNO, the resident, when asked what sexual behavior had happened, described the allegation. A review of the investigation notes and interviews conducted, clearly identified that the resident had made these statements to each of the identified four individuals. The clinical health record also revealed that the resident was provided assistance with their personal hygiene nightly. During review of the home's investigation notes, the LTC Inspector identified that there were no interviews conducted with the visiting companion, or the family member to whom the allegations were first reported. There were also no investigation notes with the registered staff who received the complaint, or the two alleged staff involved. When interviewed, the CNO stated they had not spoken to the visiting companion nor had they done any "formal" interview notes, when speaking with the family member or the staff involved. A complaint was submitted to the MOHLTC, with concerns that the home had not taken appropriate action in regards to the alleged sexual abuse. The complainant also stated they had to request that the police be called. During the inspection, it was also identified that a CIS had not been submitted to the Director. The licensee failed to take the appropriate actions in regards to the allegation of sexual abuse.

Please note: this non compliance was issued as a result of complaint log #011717-17, which was conducted concurrently with the RQI. [s. 23. (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 and ensuring that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported to the licensee, is immediately investigated and any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must 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. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
3. the program must be evaluated and updated at least annually in accordance with the evidence-based practices and, if there were none, in accordance with prevailing practices.

At the time of this inspection, the home had not completed the 2016 annual program evaluations for the following programs: Skin and Wound Care, Falls Prevention and Management, Continence Care and Bowel Management, and Pain Management, and no information had been gathered for the 2017 evaluation.

A Resident Quality Inspection was completed with a report dated February 23, 2017 (inspection #2017_569508_0002). A review of this report revealed that a Voluntary Plan of Corrections (VPC) was issued to the home, and the home at that time had not completed these program evaluations.

An interview was conducted with the CNO and DON, and it was acknowledged that to date, the home has not completed annual program evaluations for the above noted required programs. [s. 30. (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 and ensuring that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 3. the program must be evaluated and updated at least annually in accordance with the evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #11: 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 residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were 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 changes that compromises the resident's health status.

1. Resident #004 was at high nutrition risk and had a diagnosis of chronic condition. According to the resident's weight history review, they lost a significant amount of weight over three months in April, 2017, and gained a significant amount of weight over one month in May, 2017. On an identified date in July, 2017, review of resident #004's plan of care contained no nutrition assessment for April and May

2017, related to a significant weight gain over one month and significant weight loss over three months. On an identified date in July, 2017, staff #305 indicated that registered staff requested re-weighing of residents with significant weight changes. On July 5, 2017, interview staff #329 indicated that monitoring residents' weights changes and requesting re-weights of residents were to be completed by the both, for example, by registered staff and by the dietary department, which was confirmed by the Registered Dietitian (RD) and DDS. On July 5, 2017, DDS indicated that they completed nutritional assessment for resident living in an identified home area, who were assessed to be at low to moderate nutrition risk and the RD completed the rest of the residents in the home. On an identified date in July, 2017, interview with the DDS indicated that no nutrition assessment was recorded in the resident's plan care. Resident #004 with significant weight changes was not assessed using an interdisciplinary approach, and that actions were not taken and outcomes were not evaluated.

2. Resident #008 was at moderate nutrition risk and had a diagnosis of chronic condition. According to the resident's weight history review, they lost a significant amount of weight over three months in March, 2017, and a significant amount of weight over six months in April, 2017. On an identified date in July, 2017, review of resident #008's progress notes and weight history contained no nutrition assessment for March and April, 2017, related to significant weight loss over three and six months. On July 5, 2017, staff #305 indicated that registered staff requested re-weighing of residents with significant weight changes. On July 5, 2017, interview staff #329 indicated that monitoring residents' weights changes and requesting re-weights of residents were to be completed by them both, for example by registered staff and by the dietary department, which was confirmed by the RD and DDS. On July 5, 2017, DDS indicated that they completed nutritional assessment for resident living on an identified home area, who were assessed to be at low to moderate nutrition risk and the RD completed the rest of the residents in the home. On an identified date in July, 2017, interview with the DDS indicated that no nutrition assessment was recorded in the resident's plan care. The resident with significant weight changes was not assessed using an interdisciplinary approach, and that actions were not taken and outcomes were not evaluated.

3. Resident #016 was at high nutrition risk and had difficulty in swallowing and some chronic conditions. According to the resident's weight history review, they had a significant weight loss over one month in May, 2017. On an identified date in July, 2017 review of resident #016's plan of care contained no nutrition assessment for May 2017, related to a significant weight loss over one month. On

July 5, 2017, staff #305 indicated that registered staff requested re-weighing of residents with significant weight changes. On July 5, 2017, interview staff #329 indicated that monitoring residents' weights changes and requesting re-weights of residents were to be submitted by the both, for example by registered staff and by the dietary department, which was confirmed by the RD and DDS. On July 5, 2017, the RD indicated that they completed nutrition assessment for residents residing on the fifth floor of the home, assessed at high nutrition risk. On an identified date in July, 2017, interview with the RD indicated that no nutrition assessment was recorded in the resident's plan care. The resident with significant weight changes was not assessed using an interdisciplinary approach, and that actions were not taken and outcomes were not evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 and ensuring that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes were 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 changes that compromises the resident's health status, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee failed to ensure that the home’s written policy to promote zero tolerance of abuse and neglect of residents should identify measures and strategies to prevent abuse and neglect.

On July 13, 2017, the CEO acknowledged that the home’s policy titled: "Zero Tolerance of Neglect and Abuse" last revised: May 2011, did not contain measures and strategies to prevent abuse and neglect.

Please note: this non compliance was issued as a result of complaint log #011717-17, which was conducted concurrently with the RQI. [s. 96. (c)]

2. The licensee failed to ensure that the home’s written policy to promote zero tolerance of abuse and neglect of residents identified the training and retraining requirements for all staff including i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and, ii) situations that might lead to abuse and neglect and how to avoid such situations.

On July 3, 2017, the CEO acknowledged that the home’s policy titled: "Zero Tolerance of Neglect and Abuse" last revised: May 2011, did not contain the training and retraining requirements for all staff including i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and, ii) situations that might lead to abuse and neglect and how to avoid such situations.

Please note: this non compliance was issued as a result of complaint log #011717-17, which was conducted concurrently with the RQI. [s. 96. (e)]

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 and ensuring that (c) the home's written policy to promote zero tolerance of abuse and neglect of residents identifies measures and strategies to prevent abuse and neglect and (e) the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff including i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and, ii) situations that might lead to abuse and neglect and how to avoid such situations, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of the incident of a missing or unaccounted for controlled substance.

Review of the home's medication incident notification system revealed that, on April 28, 2017 during the shift change between evenings and nights, staff #157 was notified that the controlled substance count was inaccurate on the fifth floor north wing. Upon inspection, they noted the back of an identified resident's medication card had been cut on medication pocket #23, so that one half tablet of Hydromorphone was missing. The count was 29 one half tablets when it should have been 30 one half tablets. The incident report revealed that the medication was unaccounted for after they searched the medication storage areas.

During interview, staff #157 stated that they misplaced photocopies taken of the count sheet and damaged medication card; they also stated that they were unable to complete the incident report using the home's electronic medication incident notification system until their next shift on May 3, 2017.

The home's RAI Co-ordinator was tasked to compete CIS submissions in the home. During interview, they stated that they were not made aware of the missing controlled substance, had not completed a CIS in relation to it, and could not find a submission by anyone in the home for the missing controlled substance, when they reviewed CIS submissions by the home. They confirmed that a CIS should have been submitted when a controlled substance was missing or unaccounted for on April 28, 2017. [s. 107. (3)]

2. The licensee failed to ensure that the written report included actions taken in response to the incident, including:
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons.

On an identified date in July, 2017, review of CIS log # 003807-17, which contained information related to a fall with injury of resident #008 in February, 2017. The CIS was submitted to the MOHLTC on an identified date in February, 2017, and the amendment was submitted on an identified date in February, 2017. This CIS report did not contain information about substitute decision-maker for the resident was contacted. Interview with RAI Co-ordinator indicated that no POA

and/or family were contacted about long-term strategies or actions the home implemented for resident #008 related to their fall on an identified date in February, 2017, which was acknowledged by DONRC. [s. 107. (4) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that (3) the Director is informed no later than one business day after the occurrence of the incident of a missing or unaccounted for controlled substance and (4) (3) the written report included actions taken in response to the incident, including: iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that staff applied the physical device in accordance with any manufacturer's instructions.

1. On an identified date in July, 2017, resident #035 was observed in their mobility device with a restraint applied in an identified manner. Review of the resident`s plan of care (was last reviewed on an identified date in June, 2017) indicated that the resident was at risk of falls and staff were to ensure that the restraint was applied, while the resident was in their mobility device.
Review of an identified document outlined how the restraint was to be applied. On an identified date in July, 2017, staff #134 and #206 indicated that the restraint was not applied correctly, which was acknowledged by the CNO and RAI Co-ordinator.

Please note: this non-compliance was issued as a result of complaint log #027878-16, which was conducted concurrently with the RQI. (632)

2. On an identified date in July, 2017, resident # 052 was observed sitting in their mobility device with a restraint applied in an identified manner. Review of the resident`s plan of care (was initiated on an identified date in May, 2017) indicated that the restraint was to be in place, when the resident was in the mobility device. Review an identified document outlined how the restraint was to be applied. On an identified date in July, 2017, staff #359 indicated that the restraint was not applied correctly, which was acknowledged by the DONRS on an identified date in July, 2017. [s. 110. (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 and ensuring that, where a resident is restrained by a physical device, staff apply the physical device in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #15: 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 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 was a member of the staff of the home, met annually 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 home's Pharmacy and Therapeutics Committee meeting minutes between February 4, 2016 and June 8, 2017, revealed that the home's annual evaluation of the effectiveness of the medication management system in the home and recommendations for any changes necessary to improve the system had not been completed. During interview, the home's CEO and the DNRC confirmed that the 2016 annual evaluation of the home's medication management program had not been completed. [s. 116. (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 and ensuring 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, meet annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #16: 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).

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

Findings/Faits saillants :

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

At the time of this inspection, the home had not completed a 2016 Infection Prevention and Control program evaluation, and no information had been gathered for the 2017 evaluation.

A Resident Quality inspection was completed with a report date of February 23, 2017 (inspection #2017_569508_0002). A review of this report revealed that a VPC was issued to the home, and at that time had not completed this program evaluation.

An interview was conducted with the CNO and DON, and it was acknowledged that to date, the home had not completed a program evaluation for Infection Prevention and Control. [s. 229. (2) (d)]

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

1. i) On June 28, 2017, during the initial tour of the third floor, Grapeview home area's west spa room contained two stick deodorant used and unlabeled. The Cedar Spring home area's east spa room contained one used unlabeled stick deodorant, and one unlabeled nail clipper.

ii) On June 28, 2017, during the initial tour of the fourth floor, Lakeview home area's south spa room contained a used unlabeled lofa sponge and two unlabeled nail clippers. The west spa room contained unlabeled used open box of powder with powder puff, one stick deodorant used and unlabeled. The Vineland home area's north spa room contained three used unlabeled roll on deodorant.

iii) On June 28, 2017, during the initial tour of the fifth floor, Bruce Trail home area's east spa room contained two used unlabeled stick deodorants, and one unlabeled nail clipper. The Trillium Terrace home area's east spa room contained two unlabeled hairbrushes with hair in each brush.

iv) On July 4, 2017, during tour of the second floor, Pine Meadows home area's east spa room contained one opened used unlabeled jar of petroleum jelly.

The CNO acknowledged that the identified items should be labeled and not used on more than one person. The home failed to ensure that the staff participated in the implementation of the infection prevention and control program in the home. (536)

2. Review of the home's Infection and Prevention and Control Program, revealed specific directions for staff related to use of identified devices.

During the course of this inspection on identified dates in July, 2017, resident #041 was observed sitting in their mobility device, while in the hallway, their bedroom, the dining room and while being assisted by PSW staff. During each of these observations, the resident's device was observed to be positioned in a manner that contradicted the Infection Prevention and Control Program's directions for staff. During interview, staff #281 stated that they were aware of how to adjust the position of the device to prevent this from occurring.

During interview, the DONRC who was the home's Infection Prevention and Control lead stated that the home's expectation was that the staff would adhere to the directions related to the positioning of the device. (526) [s. 229. (4)]

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 and ensuring that (2) (d) the infection control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there is none, in accordance with prevailing practices and (4) all staff participated in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a 24-hour admission care plan was developed for resident #026 and communicated to direct care staff within 24 hours of the resident's admission to the home.

A review of resident #026's clinical health records revealed, that the resident was admitted on an identified date in October, 2016. The admission progress notes by staff #157 revealed, that during family interview, it was identified that resident #026 had a skin treatment on an identified area. The Head to Toe Admission Assessment was completed the day of admission, however, it did not identify any altered skin integrity. On an identified date in November, 2016, the progress notes revealed a referral for a skin and wound assessment for resident #026. Also, on an identified date in November, 2016, the resident developed an identified symptom. On an identified date in November, 2016, the resident was seen by the physician. The physician indicated a diagnosis and prescribed two medications. The RAI Co-ordinator acknowledged that a complete skin assessment had not been done for resident #026 by the registered staff on an identified date in November, 2016. A review of the resident's 24 hour care plan was completed by the Inspector and identified that no documentation was entered in the skin care of wound section of the admission care plan. This was confirmed by the RAI Co-Ordinator. The home failed to ensure that resident #026's altered skin integrity, including interventions were included in the 24-hour admission care plan.

Please note: this non compliance was issued as a result of complaint log #005978-17, which was conducted concurrently with the RQI. (536) [s. 24. (2) 7.]

WN #18: The Licensee has failed to comply with LTCHA, 2007, s. 77. Orientation for volunteers
Every licensee of a long-term care home shall develop an orientation for volunteers that includes information on,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) the duty under section 24 to make mandatory reports;
(e) fire safety and universal infection control practices;
(f) any other areas provided for in the regulations; and
(g) the protections afforded by section 26. 2007, c. 8, s. 77.

Findings/Faits saillants :

1. The licensee failed to ensure that they developed an orientation for volunteers that included information on, (f) any other areas provided for in the regulations, and (g) the protections afforded by section 26. 2007, c. 8, s. 77.

The orientation provided for all volunteers in the home must include education of whistle-blowing protection as outlined in s. 26(1) of the Long Term Care Homes Act, 2007, In accordance with r. 223 (2) 2, every long term care home shall ensure that every volunteer received the orientation provided for in section 77 of the Act. O. Reg 79/10, specifically with respect to the emergency evacuation procedures in the home.

Education was provided to all volunteers using "the Albright Manor Volunteer and Student Handbook". As acknowledged by the Manager of Programs and Support Services, this handbook covered all the education that was provided to all volunteers. A review of this handbook revealed a statement that Albright Manor was committed to ensuring there would be no retaliation to anyone who reported any of the above actions. There was no education provided directly related to whistle-blowing protection.

The handbook reviewed fire safety and prevention, and indicated that a volunteer may be asked to assist in checking rooms to evacuate residents. It did not include emergency and evacuation procedures.

In an interview conducted with the Manager of Program and Support Services, it was acknowledged that the orientation package for volunteers did not include education on whistle-blowing protection or emergency and evacuations procedures. [s. 77.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident for an offense which may constitute a criminal offense.

On an identified date in June, 2017, a family member of resident #031 reported to the home an alleged incident of sexual abuse against the resident. The police were not informed until an identified date in June, 2017, when the family requested the police be notified. The CNO when interviewed, agreed that the resident had told a visitor, registered nurse, a family member and then themselves that they had been sexually abused, however, the CNO did not believe it had occurred and did not contact the police. The CNO then told the inspector "Sometimes residents says things of a fantastical nature and you just know it isn't true".

Please note: this non compliance was issued as a result of complaint log #011717-17, which was conducted concurrently with the RQI. [s. 98.]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that an analysis of every incident of abuse or neglect of a resident at the home was undertaken promptly after the licensee becomes aware of it.

During interview with both the CEO and the CNO the LTC Inspector asked if an annual evaluation had been completed in regards to abuse. The CEO, CNO and the DONRC, when interviewed, all stated that an analysis of every incident of abuse or neglect had not been completed for 2016.

Please note: this non compliance was issued as a result of complaint log #011717-17, which was conducted concurrently with the RQI. [s. 99. (a)]

2. The licensee failed to ensure that once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

During interview with both the CEO and the CNO, the LTC Inspector was asked if an annual evaluation had been completed in regards to abuse. The CEO, CNO and the DONRS, when interviewed, all stated that an annual evaluation had not been completed for 2016.

Please note: this non compliance was issued as a result of complaint log #011717-17, which was conducted concurrently with the RQI. [s. 99. (b)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written procedures required under section 21 of the Act incorporated the requirements set out in section 101. O. Reg. 79/10, s. 100.

On July 14, 2017, the CEO, when interviewed, acknowledged that the home did not have a formal policy for dealing with complaints. The CEO stated that the "Albright Manor Resident Handbook" identified how to deal with a complaint. A review of the Resident Handbook identified there was no written procedure in relation to: dealing with written and verbal complaints that included (2) ensuring that a documented record was kept in the home, (3) a written procedure ensuring that the documented record was reviewed and analyzed quarterly or, (4) in relation to subsection (2) and (3) not applying in respect to verbal complaints that the licensee was able to resolve within 24 hours of the complaint being initiated. On July 17, 2017, the CNO, when interviewed, provided the inspector with a "Departmental Concern/Compliment Feed Back Form", which the home had started to use, however, the CNO acknowledged that there was no written procedure to meet the requirements of the legislation.

Please note: this non compliance was issued as a result of complaint log #011717-17, which was conducted concurrently with the RQI. [s. 100.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the documented record of complaints received was reviewed and analyzed for trends, at least quarterly.

On July 19, 2017 the CNO acknowledged that the home had not reviewed and analyzed for trends quarterly on the documented record of complaints received in 2017. [s. 101. (3) (a)]

Issued on this 31 day of October 2017 (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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : YULIYA FEDOTOVA (632) - (A1)

Inspection No. / No de l'inspection : 2017_560632_0013 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 012996-17 (A1)

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

Report Date(s) / Date(s) du Rapport : Oct 31, 2017;(A1)

Licensee / Titulaire de permis : ALBRIGHT GARDENS HOMES INC.
5050 Hillside Drive, Beamsville, ON, L0R-1B2

LTC Home / Foyer de SLD : Albright Gardens Homes, Incorporated
5050 Hillside Drive, Beamsville, ON, L0R-1B2

Name of Administrator / Nom de l'administratrice ou de l'administrateur : William ter Harmsel

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

To ALBRIGHT GARDENS HOMES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee shall complete the following:

1. Develop and implement a system for monitoring that all residents in the home are bathed twice weekly by the method of their choice.

2. Develop a bathing plan for staff to implement when they are short staffed.

3. Ensure there is an established process for the staff to communicate shift to shift regarding completion of bathing.

4. Ensure all nursing and personal care staff are aware of this plan.

5. Any resident who misses a scheduled bath or shower due to the home being short staffed, has the missed bath or shower documented and made up the same week.

6. Develop an auditing process to ensure residents are receiving minimum bathing requirements.

Grounds / Motifs :

1. This order is made up on the application of the factors of severity (1), scope (3), and compliance history (4), in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of minimal risk, the scope of this being widespread incidents, and the licensee history of non-compliance with a Voluntary Plan of correction (VPC) in January 2017, during the Resident Quality Inspection for r. 33.

The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

1. A review was completed of ten random residents for baths received during the four week cycle on identified dates in June, 2017. The following was identified:

i) A review of resident #053's written plan of care indicated that this resident was to receive a bath on two specific dates each week. Point of Care (POC) was reviewed as it related to bathing for resident #053. During a four week review, this resident was to have received eight baths. According to the follow up question report for this resident, they received a total of six baths during this period of time.

ii) A review of resident #054's written plan of care indicated that this resident was to receive a bath on two specific dates each week. POC was reviewed as it related to bathing for resident #054. During a four week review, this resident was to have received eight baths. According to the follow up question report for this resident, they received a total of four baths during this period of time and refused one bath.

iii) A review of resident #055's written plan of care indicated that this resident was to receive a bath on two specific dates each week. POC was reviewed as it related to bathing for resident #055. During a four week review, this resident was to have received eight baths. According to the follow up question report for this resident, they received a total of three baths during this period of time, refused two baths and one response was documented as not applicable.

iv) A review of resident #056's written plan of care indicated that this resident was to receive a bath on two specific dates each week. POC was reviewed as it related to bathing for resident #056. During a four week review, this resident was to have received eight baths. According to the follow up question report for this resident, they received a total of five baths during this period of time. Three responses were

documented as not applicable.

v) A review of resident #057's written plan of care indicated that this resident was to receive a bath on two specific dates each week. POC was reviewed as it related to bathing for resident #057. During a four week review, this resident was to have received eight baths. According to the follow up question report for this resident, they received a total of four baths during this period of time. One response was documented as not applicable.

vi) A review of resident #058's written plan of care indicated that this resident was to receive a bath on two specific dates each week. POC was reviewed as it related to bathing for resident #058. During a four week review, this resident was to have received eight baths. According to the follow up question report for this resident, they received a total of four baths during this period of time. Two responses were documented as not applicable.

vii) A review of resident #059's written plan of care indicated that this resident was to receive a bath on two specific dates each week. POC was reviewed as it related to bathing for resident #059. During a four week review, this resident was to have received eight baths. According to the follow up question report for this resident, they received a total of three baths during this period of time.

viii) A review of resident #060's written plan of care indicated that this resident was to receive a bath on two specific dates each week. POC was reviewed as it related to bathing for resident #060. During a four week review, this resident was to have received eight baths. According to the follow up question report for this resident, they received a total of two baths during this period of time.

ix) A review of resident #061's written plan of care indicated that this resident was to receive a bath on two specific dates each week. POC was reviewed as it related to bathing for resident #061. During a four week review, this resident was to have received eight baths. According to the follow up question report for this resident, they received a total of five baths during this period of time.

x) A review of resident #062's written plan of care indicated that this resident was to receive a bath on two specific dates each week. POC was reviewed as it related to bathing for resident #062. During a four week review, this resident was to have received eight baths. According to the follow up question report for this resident, they

received a total of five baths during this period of time.

When interviewed PSW staff #235, #269 and #181 acknowledged that "not applicable" meant short staffed. The RAI Co-ordinator confirmed that no signature meant no bath had occurred. During review of the staffing schedules for identified dates in June, 2017, with the nursing secretary, it was also noted that 25 missed baths occurred when the home had full staffing and 13 missed baths occurred when the home was short staffing. A total of 38 baths were missed in a four week period which equalled 48 percent (%) of baths in a four week period being missed. This was confirmed by the RAI Co-Ordinator. (536)

2. Resident #026's family member complained that their family member did not always get their bath or shower. A review of resident #026's written plan of care indicated that this resident was to receive a bath or shower during the evening shift on two identified dates of the week. Point of Care (POC) was reviewed as it related to bathing for resident #026.

According to the follow up question report found on the home's electronic medical record, resident #026 did not receive a bath or shower twice per week on four occasions on identified dates between April and June, 2017. The task response indicated "Not Applicable" by staff #298 on an identified date in April, 2017 and by staff #250 on an identified dates in May and June, 2017. During interviews, staff #298 and #250 confirmed that they had missed some of resident #026's baths/showers and that they were not able to make up the baths with a different method of bathing or on a different day. They stated that when there were only two staff members assigned to care for 30 residents on the northeast third floor during the evening shift, it was difficult for them to get the evening baths completed. They stated that they were instructed to indicate "Not Applicable" if they were unable to complete a bath/shower. They stated that they did not offer resident #026 an alternative since they had no time.

Please note: this area of non compliance was identified during a complaint inspection, log #005978-17, conducted concurrently during this Resident Quality Inspection. (526)

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

Jan 05, 2018

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Order / Ordre :

The Licensee shall complete the following:

1. Update the home's policies for the medication management system to reflect legislative requirements in relation to documenting, reviewing, and analysis of medication incidents and adverse drug reactions, taking corrective action and maintaining written records of the home's management of these incidents.

2. Retrain all registered staff involved in medication distribution on actions to be taken when a medication error occurs.

3. Document, review and analyze medication incidents and adverse drug reactions, take corrective action and maintain written records of the home's management of these incidents.

Grounds / Motifs :

1. This order is made up on the application of the factors of severity (2), scope (3), and compliance history (3), in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of minimal risk, the scope of this being widespread incidents, and the licensee history of previous written notice (WN) in January 2016, during the Resident

Quality Inspection for r. 135.

The licensee failed to ensure that:
(a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed
(b) corrective action was taken as necessary, and
(c) a written record was kept of everything required under clauses (a) and (b).

1. According to interviews with the Pharmacist and DONRC, the home's process for destruction of controlled substances involved registered staff co-signing count sheets for a given medication. They would then deposit the medications to be discarded along with the count sheet into the slot of a double locked medication box located in a treatment room on the second, third, fourth and fifth floors. Together, the Pharmacist and staff #206 would remove the contents of the boxes, ensure the count was accurate, destroy and dispose of the denatured medications for pick up from a secured area in the home by a vendor.

According to the Critical Incident System (CIS), on March 24, 2016, the home reported that controlled substances were missing/unaccounted for from the surplus medication box located on the fifth floor as of March 23, 2016. During interview with the home's RAI Co-odinator and review of notes provided by the home, the following controlled substances were observed to be missing by staff #206 and the Pharmacist who were counting controlled substances that had been discarded and were to be destroyed:

i) 55 tablets of Percocet tablets contained within two (2) cards discarded on January 3 and 5, 2016; and
ii) 22 tablets Ativan 0.5 milligram (mg) discarded on November 12, 2015.

According to CIS #C501-000002-16, police were not notified initially since "there are no suspects at this time"; police were notified after a telephone call with an inspector related to the CI report submitted by the home. The home's Pharmacist confirmed that the fifth floor medication box had not been emptied between October 8, 2015 and March 23, 2016. The Pharmacist and DONRC stated that it was determined that the slots on the boxes were large enough to enable the removal of medications from the box after they had been deposited there for destruction. According to the DONRC, the Restorative Care Coordinator and PSW #275, all registered staff and restorative care PSWs had access to the treatment rooms that contained the narcotic

drop boxes for an unspecified time prior to June 17, 2016. The Pharmacist indicated that they had been in the home on May 6, 2016 and on that day made a request to a vendor that four (4) industry standard double locked boxes be delivered to the home. These arrived in the home on May 10, 2016 but were not installed until June 17, 2016.

The home's RAI Co-ordinator, the DONRC, Pharmacist, and the CEO could not confirm whether any staff had been interviewed in relation to the incident, the extent of the review and analysis, or if there had been any response to prevent a similar incident from occurring other than the arrival of new boxes to the home. The home could not provide any documentation of the review, analysis, responses or implementation of these responses to this incident.

According to CIS C501-000008-17, on June 17, 2017, the Pharmacist and staff #206 discovered additional controlled substances that had gone missing from the fifth floor drop box as follows:

i) 30.5 tablets Ativan 0.5mg, put in box on April 21, 2016
ii) 30 tablets of Ativan 1 mg, put in box on May 25, 2016
iii) 26.5 tablets of Ativan 0.5mg, put in box on June 1, 2016
iv) 28 tablets of Dialudid 1 mg, put in box on June 9, 2016

According to interviews with the Pharmacist, they had not been asked to empty and destroy the contents of the fifth floor box since March 23, 2016, when the previous incident was identified. They indicated that there was no regular schedule for the destruction of controlled substances in the home. According to the CEO, DONRC, and the RAI Coordinator, steps were taken to prevent further incidents after June 17, 2017, including assigning keys for each treatment room only to registered staff on their respective floors; removing materials from treatment rooms so that restorative PSWs would not have access to the area where discarded controlled substances were located, and installation of the boxes that had been in the home since May 10, 2016; these new boxes had a smaller drop slot, a metal deterrent bar and a larger capacity. The Pharmacist was to come to the home for drug destruction more frequently however did not empty and destroy the contents of the fifth floor box with a registered staff until October 23, 2016. There have been no further missing or unaccounted for controlled substances from drop boxes since June 17, 2016.

During an interview, the CEO indicated that they were not aware if corrective action

had taken place to prevent additional controlled substances from going missing or unaccounted for after March 23, 2016, and that the documentation of any investigation, review and analysis of the incident that occurred on March 23, 2016, including a police record could not be provided.

Please note: This area of non compliance was identified during a CI inspection, log #008878-16, conducted concurrently during this Resident Quality Inspection.

2. Review of the home's Medication Incident Notification system revealed that, on an identified date in April, 2017 during the shift change between evenings and nights, staff #157 was notified that the controlled substance count was inaccurate on the fifth floor north wing. Upon inspection, they noted the back of resident #050's medication card had been cut on medication pocket #23, so that one half tablet of pain management medication was missing. The count was 29 one half tablets when it should have been 30 one half tablets. The incident report revealed that the medication was unaccounted for after they searched the medication storage areas.

During interview, staff #157 stated that they misplaced photocopies taken of the count sheet and damaged medication card; they also stated that they were unable to complete the incident report using the home's electronic medication incident notification system until their next shift on an identified date in May, 2017. Interview with the DONRC revealed that they had not been involved with this incident, that the incident report did not include a review, analysis or corrective actions that might have been implemented. They stated that they could not locate any notes about a review, analysis or corrective actions to prevent this incident from occurring again.

3. According to the home's Medication Incident Notification System the home had four (4) medication incidents reported in April 2017, three (3) reported in May 2017, and six (6) reported in June 2017. Of these 13 incidents, 11 involved residents. Review of the documentation provided by the home during this inspection could not confirm that these incidents had been reviewed or analyzed, or that corrective action was taken except in one incident where a staff person had been disciplined. During interview, the Pharmacist stated that they were not involved in review and analysis of medication incidents involving nursing actions. During interview, the DONRC stated that they were periodically involved in responding to medication incidents by speaking with staff, however, they did not maintain notes. They were not aware if corrective action had been taken in relation to these medication incidents.

During an interview, the CEO stated that the CNO was not in the home and would investigate medication incidents. The CEO confirmed that documents to support the review and analysis of these incidents along with corrective action, if any, could not be found.
(526)

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

Jan 05, 2018

Order # /
Ordre no : 003

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 complete the following:

1. Provide mandatory re-education for all staff on prevention of Abuse and Neglect, including reporting expectations, whistle-blowing protection, as well as the types of abuse and what constitutes neglect of a resident.

2. Provide mandatory re-education for all staff on the Residents' Bill of Rights.

3. Initiate quality monitoring activities and analysis to ensure ongoing compliance with the home's abuse policy.

4. Ensure documentation is available on staff retraining on Prevention of Abuse and Neglect and Resident Lifting Policy.

Grounds / Motifs :

1. This order is made up on the application of the factors of severity (2), scope (3), and compliance history (2), in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of minimal risk, the scope of this being widespread incidents, and the licensee history of previous non-compliance (unrelated).

The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

O. Reg. 79/10 defines "abuse" in r. 2. (1) for the purposes of the definition of “abuse” in subsection 2 (1) of the Act,

“emotional abuse” means,

(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or

(b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their

consequences; ("mauvais traitement d'ordre affectif")

"physical abuse" means, subject to subsection (2),

(a) the use of physical force by anyone other than a resident that causes physical injury or pain,

(b) administering or withholding a drug for an inappropriate purpose, or

(c) the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitement d'ordre physique")

"verbal abuse" means,

(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or

(b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences. ("mauvais traitement d'ordre verbal") O. Reg. 79/10, s. 2 (1).

(2) For the purposes of clause (a) of the definition of "physical abuse" in subsection (1), physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances. O. Reg. 79/10, s. 2 (2).

O. Reg. 79/10, s. 5. defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

1. On an identified date in April, 2017, the home submitted a CI C501-000008-17 for abuse/neglect, reporting that on an identified date in April, 2017, the Substitute Decision Maker (SDM) of resident #028 reported an incident that had occurred earlier in the day.

The home's investigation concluded that staff #373 forcefully transferred resident #028 from their bed to their mobility device. This resident was physically lifted by staff #373 and during this incident, the resident sustained some injuries.

The plan of care for resident #028 at the time of the incident, indicated that this resident was to be transferred by two staff members with the use mechanical device.

On an identified date in April, 2017, resident #028 expressed being upset and frightened about this incident that occurred on an identified date in April, 2017. The CNO acknowledged that on an identified date in April, 2017, resident #028 was not protected from abuse. Staff #373 was disciplined as a result of this incident.

Please note: this non-compliance was issued as a result of CI log #007022-17, which was conducted concurrently with the RQI.
(611)

2. On an identified date in July, 2017, staff #112 was providing care to resident #063 in their room. Staff #159 was in the hallway outside of the room, and heard staff #112 speaking in a loud tone to resident #063. This resident was witnessed to have refused the provision of care at that time and was disappointed. Staff #112 was witnessed to be verbally abusive with the resident. Upon witnessing the incident, staff #159 intervened, provided emotional support to resident #063, and requested that staff #112 leave the room.

The home conducted an investigation regarding this incident, and disciplinary action took place as a result of the incident.
In an interview conducted with the CNO, it was acknowledged that resident #063 was not protected from abuse.

Please note: this non-compliance was issued as a result of CI log # 014405-17, which was conducted concurrently with the RQI.
(611)

3. The plan of care for resident #030 revealed they had a loss of intellectual capacity, difficulty in swallowing and required a use of a mechanical device for transfers assisted by two staff. On an identified date in May, 2017, the home submitted a CI C501-000013-17, reporting that on an identified date in May, 2017, the resident was found in their bathroom unattended in a mechanical device used for transferring. The home's investigation concluded that the resident had been unattended in their bathroom, however, the investigation was inconclusive as all the staff working that shift denied that. The clinical health record indicated that resident #030 had a injury as a result of being left unattended. On an identified date in July, 2017, the CNO acknowledged that the policy titled: "Resident Lifting Policy, N-10.9", revised September 2010, stated at least one staff should have remained with the resident. The CNO acknowledged that on an identified date in May, 2017, that resident #030 was neglected when staff provided assistance to the resident and left them unattended.

Please note: this non-compliance was issued as a result of CI log #009894-17, which was conducted concurrently with the RQI.
(536)

4. The plan of care for resident #031 revealed they had a loss of intellectual capacity, difficulty in swallowing and required a mechanical lift for all transfers assisted by two staff. On an identified date in May, 2017, the home submitted a CI C501-000013-17, reporting that on an identified date in May, 2017, the resident was found in their bathroom unattended in a mechanical device. The home's investigation concluded that the resident had been unattended in their bathroom, however, the investigation was inconclusive as all the staff working that shift denied that. The clinical health record indicated that resident #031 had an injury as a result of being left unattended for an extended period of time. On July 7, 2017, the CNO acknowledged that the policy titled: "Resident Lifting Policy N-10.9", revised September 2010, stated at least one staff should have remained with the resident. The CNO acknowledged that on an identified date in May, 2017, that resident #031 was neglected when staff placed assistance to the resident and left them unattended.

Please note: this non-compliance was issued as a result of CI log #009894-17, which was conducted concurrently with the RQI. (536)
(536)

5. The plan of care for resident #038 revealed they had severe cognitive impairment, and required a mechanical lift for all transfers.

On an identified date in November, 2016, the home submitted Critical Incident (CI) C501-000021-16, reporting that on an identified date in November, 2016, the resident was found unattended in a mechanical device, outside of a resident room. The home's investigation concluded that resident #038 may have pushed the device from the washroom to outside the resident room, as this resident was in the area when found by staff. As a result of this incident, resident #038 developed altered skin integrity.

On an identified date in July, 2017, the CNO acknowledged that the policy titled "Resident Lifting Policy, N-10.9" revised September 2010, stated at least one staff should have remained with the resident.

The CNO acknowledged that on an identified date in November, 2016, resident #038 was neglected when staff #178 left this resident in a mechanical device unattended.

Please note: this non-compliance was issued as a result of CI log # 032420-16 and log #032494-16, which was conducted concurrently with the RQI.
(611)

6. The plan of care for resident #023 revealed they had a loss of intellectual capacity, and required a mechanical lift for all transfers.
On an identified date in October, 2016, the home submitted Critical Incident C501-000017-16, reporting that on an identified date in October, 2016, the resident was found unattended in their bathroom by the afternoon shift. The home's investigation concluded that the resident had been unattended in their bathroom. The clinical health record indicated that resident #023 had altered skin integrity as a result of being left unattended.

On an identified date in July, 2017, the CNO acknowledged that the policy titled "Resident Lifting Policy, N-10.9" revised September 2010, stated two staff must be present when transferring resident. The CNO also stated that while the resident was in their bathroom, at least one staff should have remained with the resident.

The CNO acknowledged that on an identified date in October, 2016, resident #023 was neglected when staff #371 left the resident unattended in their bathroom.

Staff #371 was counselled for their neglect of resident #023.

Please note: this non-compliance was issued as a result of CI log # 030130-16, which was conducted concurrently with the RQI.
(611)

7. The plan of care for resident #032 revealed they had loss of intellectual capacity, were at risk for falls and skin impairment and required a mechanical assistance for all transfers.

On an identified date in April, 2016, the home submitted CI C501-000004-16, reporting that on an identified date in April, 2016, the resident was found unattended in their bathroom by the afternoon shift. The home's investigation concluded that the resident had been unattended in their bathroom. The skin assessment completed by registered staff after the incident occurred revealed they had altered skin integrity.

On an identified date in June, 2017, the CNO acknowledged that the policy titled "Resident Lifting Policy, N-10.9" revised September 2010, stated two staff must be present when using the mechanical device. The CNO also stated that, while the resident was in their bathroom, at least one staff should have remained with the resident.

The CNO acknowledged that on an identified date in April, 2016, resident #032 was neglected when staff #100 provided assistance to the resident and left them unattended.

Staff #100 received discipline for their neglect of resident #032.
Please note: this non compliance was issued as a result of CI log #012818-16, which was conducted concurrently with the RQI.
(130)

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

Nov 15, 2017(A1)

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee shall complete the following:

1. Ensure staff follow the residents' plans of care when assisting residents in relation to transferring and positioning, according to their assessed needs and preferences.

2. Provide all direct care staff retraining regarding safe transferring and positioning for assisting residents.

3. Ensure staff competency related to lifts and transfers be audited annually according to the home's policy.

4. Ensure staff who do not pass the competency audit be paired with an employee who has passed their audit, re-educated, and retested.

5. Establish an auditing process to ensure that staff using transferring and positioning devices or techniques to assist residents are using safe techniques appropriate to the needs of the resident.

6. Ensure documentation be retained of training, staff audit results, and retraining.

Grounds / Motifs :

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

1. This order is made up on the application of the factors of severity (2), scope (3), and compliance history (2), in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of minimal harm or potential for actual harm, the scope of this being widespread incidents, and the licensee history of previous unrelated non-compliance (NC) in January, 2017, during the Resident Quality Inspection (RQI).

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

1. On an identified date in April, 2017, the home submitted CI C501-000008-17, reporting that on an identified date in April, 2017, the SDM of resident #028 reported an incident that had occurred earlier in the day.

The home's investigation concluded that staff #373 forcefully transferred resident #028 from their bed to their mobility device. This resident was physically lifted by staff #373, and during this incident, the resident sustained some injuries.

The plan of care for resident #028 at the time of the incident, indicated that this resident was to be transferred by two staff members with the use of a mechanical device.

The CNO acknowledged that on an identified date in April, 2017, staff #373 did not use safe transferring techniques when resident #028 was forcefully transferred to their mobility device.

Please note: this non-compliance was issued as a result of CI log #007022-17, which was conducted concurrently with the RQI.
(611)

2. The plan of care for resident #030 revealed they had a loss of intellectual capacity, difficulty in swallowing and required a mechanical device for all transfers assisted by two staff. On an identified date in May, 2017, the home submitted a CI C501-000013-17, reporting that on an identified date in May, 2017, the resident was found unattended in their bathroom by the day shift. The home's investigation concluded that the resident had been unattended. As a result of this incident, resident #030 sustained an injury. On an identified date in July, 2017, the CNO acknowledged that the policy titled: "Resident Lifting Policy N-10.9", revised September 2010, stated at least one staff should have remained with the resident. The CNO also acknowledged, staff did not use safe transferring techniques when resident #030 was transferred using a mechanical device.

Please note: this non-compliance was issued as a result of CI log #009894-17, which was conducted concurrently with the RQI. (536)

3. The plan of care for resident #038 revealed they had severe cognitive impairment, and required a mechanical lift for all transfers.

The home submitted CI, reporting that on an identified date in November, 2016, the resident was found unattended in a mechanical device, outside of a resident room.

The home's investigation concluded that resident #038 may have pushed the mechanical device from the washroom to outside the resident's room, as this resident was in the area when found by staff. As a result of this incident, resident #038 sustained an injury.

On July 7, 2017, the CNO acknowledged that the policy titled "Resident Lifting Policy, N-10.9" revised September 2010, stated at least one staff should have remained with the resident.

The CNO acknowledged, that on an identified date in November, 2016, staff #178 did not use safe transferring techniques when resident #038 was transferred using a mechanical device and the resident was left unattended.

Please note: this non-compliance was issued as a result of CI log # 032420-16/log #032494-16, which was conducted concurrently with the RQI.
(611)

4. On an identified date in October, 2016, the home submitted CI C501-000017-16, reporting that on an identified date in October, 2016, resident #023 was found unattended in their bathroom by the afternoon shift. The home's investigation concluded that the resident had been unattended.

The home's policy titled "Resident Lifting Policy, N-10.9" revised September 2010, stated two staff must be present when using a mechanical device for transferring.

The plan of care for resident #023 revealed they had severe cognitive impairment required a mechanical device for all transfers.
The CNO confirmed that staff #371 did not use safe transferring techniques when resident #023 was transferred using a mechanical lift and left this resident unattended for an excessive amount of time.

Please note: this non-compliance was issued as a result of CI log #030130-16, which was conducted concurrently with the RQI.
(611)

5. On an identified date in April, 2016, the home submitted CI C501-000004-16, reporting that on an identified date in April, 2016, the resident was found unattended in their bathroom by the afternoon shift. The home's investigation concluded that the resident had been unattended.

The home's policy titled "Resident Lifting Policy, N-10.9" revised September 2010, stated two staff must be present when using the mechanical device.

The plan of care for resident #032 revealed they had a loss of intellectual capacity and were at risk for falls and skin impairment and required a mechanical device for all transfers.

The CNO confirmed that on an identified date in April, 2016, staff #100 did not use safe transferring techniques when resident #032 was transferred using mechanical device and left unattended.

Please note: this non compliance was issued as a result of CI log #012818-16, which was conducted concurrently with the RQI. (130)

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

Jan 05, 2018

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

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

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the Height and Weight Monitoring Policy and Head Injury Routine Policy are implemented in the home.
The plan shall include:

1. Staff education on the Height and Weight Monitoring Policy including action to be taken when there is a discrepancy in the residents weight.

2. Staff education and training on the Head Injury Routine Policy.

3. Training related to Height and Weight Monitoring and Head Injury Routine Policy will be recorded.

4. An auditing process to ensure that all residents, including resident #029, are assessed based on the Head Injury Routine Policy.

5. An auditing process to ensure that all residents' weights, including residents' #004, #008, and #016 are recorded and monitored according to the Height and Weight Monitoring Policy.

6. The plan will identify who is responsible for policy review, training and auditing of the effectiveness of the training provided.

7. The plan will identify the target audience for the specified training and how training will be addressed for those who do not attend scheduled training

This plan is to be submitted to yuliya.fedotova@ontario.ca by November 6, 2017.

Grounds / Motifs :

1. This order is made up on the application of the factors of severity (2), scope (2), and compliance history (4), in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of minimal harm or potential for actual harm, the scope of this being pattern, and the licensee history of ongoing non-compliance despite previous action taken by ministry in January 2017, during the Resident Quality Inspection for s. 8.

The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act and in accordance with r. 48 required the home to develop and implement a falls prevention and management program.

1. A review of a CIS submitted by the home and progress notes indicated that on an identified date in April, 2017, resident #029 had an unwitnessed fall with an injury. Review of clinical records indicated that head injury routine was initiated several hours later by the home's staff. Review of "Falls Prevention Management Program N - 9.5.6" revised April, 2017, contained the information about initiation of head injury routine as a part of a post fall assessment. Review of "Head Injury Routine Policy N - 9.6.1" revised March, 2012, stated that it was to be initiated by RN or RPN for a total of 72 hours post fall for each resident, who had unwitnessed fall, a witnessed fall with a possible head injury and who was on anti-coagulant therapy. On July 17, 2017, an interview with DONPS indicated that head injury routine was not initiated post fall as a part of full head-to-toe post fall assessment and was completed several hours later. The home's staff did not comply with the home's "Falls Prevention Management Program" and "Head Injury Routine Policy N - 9.6.1", which was a part of "Falls Prevention and Management Program".
Please note: this non-compliance was issued as a result of CI log # 007966-17, which was conducted concurrently with the RQI. (632)

2. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long- term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act and in accordance with r. 68. (2) (a), which included development and implementation in consultation with a registered dietitian who was a member of the staff of the home, of policies and procedures relating to nutrition care and dietary service and hydration, and r. 68. (2) (e), which required that the program include a weight monitoring system to measure and record the weight and height.

The home’s Dietary Policy and Procedural Manual: "Height and Weight Monitoring Policy D-1.26", revised December 2016, indicated that the Unit Supervisor would verify by re-weighing resident if any weight change of (+/-) two kg or more from the previous month occurred, which would be completed within 24 hours. On an identified date in July, 2017, review of resident #016’s weight history contained information about weight changes of more than two kg from the month of May 2017. During this period of time the resident‘s significant weight changes were not verified. On July 5, 2017, staff #329 indicated that the registered staff requested in the home re-weighing of residents with significant weight changes, which was confirmed by the RD. The home’s staff did not comply with the home’s Dietary Policy and Procedural Manual: "Height and Weight Monitoring Policy D-1.26".
(632)

3. The home's Dietary Policy and Procedural Manual: "Height and Weight Monitoring Policy D–1.26", revised December 2016, indicated that the Unit Supervisor would verify by re-weighing resident if any weight change of (+/-) two kg or more from the previous month occurred, which would be completed within 24 hours. On an identified date in July, 2017, review of resident #008's weight history contained information about weight changes of more than two kg from previous months: for March and April, 2017. During this period of time the resident's significant weight changes were not verified. On July 5, 2017, staff #329 indicated that the registered staff requested in the home re-weighing of residents with significant weight changes, which was confirmed by the RD. The home's staff did not comply with the home's Dietary Policy and Procedural Manual: "Height and Weight Monitoring Policy D-1.26". (632)

4. The home's Dietary Policy and Procedural Manual: "Height and Weight Monitoring Policy D-1.26", revised December 2016, indicated that the Unit Supervisor would verify by re-weighing resident if any weight change of (+/-) two kg or more from the previous month occurred, which would be completed within 24 hours. On an identified date in July, 2017, review of resident #004's weight history contained information about weight changes of more than two kg from previous months: for April and May 2017. During this period of time the resident's significant weight changes were not verified. On July 5, 2017, staff #329 indicated that the registered staff requested in the home re-weighing of residents with significant weight changes, which was confirmed by the RD. The home's staff did not comply with the home's Dietary Policy and Procedural Manual: "Height and Weight Monitoring Policy D-1.26". (632)

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

Jan 05, 2018

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

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 31 day of October 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : YULIYA FEDOTOVA - (A1)

Service Area Office / Bureau régional de services : Hamilton