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 sous la Loi de 2007 sur 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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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 15, 2017	2017_420643_0021	025111-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE JEWISH HOME FOR THE AGED
3560 BATHURST STREET NORTH YORK ON M6A 2E1

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

THE JEWISH HOME FOR THE AGED (2824)
3560 BATHURST STREET NORTH YORK ON M6A 2E1

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

ADAM DICKEY (643), SHIHANA RUMZI (604)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 2, 3, 6-10 and 14-17, 2017.

The following critical incident was inspected concurrently with the Resident Quality Inspection (RQI):
Log #025208-17; Critical Incident System Report (CIR) - related to injury with unknown cause.

The following complaints were inspected concurrently with the RQI:
Log #023542-17 - related to falls prevention and management; and
Log #025238-17 - related to alleged abuse and infection prevention and control.

The following compliance order follow-up was inspected concurrently with the RQI:
Log #017462-17 - related to plan of care.

During the course of the inspection, the inspector(s) spoke with The Director of Care and Resident Experience (DOC), Associate Director of Care (ADOC), Long-Term Care Directors (LTCD), infection prevention and control lead, staff educator, Registered Nurses (RN), Registered Practical Nurses (RPN), personal support workers (PSW), private sitters, Residents' Council and Family Council Representatives, residents and family members.

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of health records, staff training records, meeting minutes for Residents' Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

- **4 WN(s)**
- **3 VPC(s)**
- **1 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
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2017_486653_0012	643

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. 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 has failed to ensure that the resident-staff communication and response system was on at all times.

During stage one observations, on an identified home area, in the room of resident #001, the inspector observed the following:
-The bed room call bell was activated by the inspector through the call bell panel located at the head of the bed. The inspector observed outside the room on the left upper wall a green light flashed indicating the call bell was activated.
-The washroom call bell was activated, and outside the room on the left upper wall a red light flashed indicating the call bell was activated.
In both cases when the call bells were activated the call bells were not audible and ceiling call bell display panel "Austco" screen did not display the location of the call bells.

An interview conducted with Registered Nurse (RN) #100, indicated when a call bell is activated it sounds and is displayed on the ceiling call bell display panel. The inspector and RN went to resident #001's room, the RN indicated the red and green light was lit outside the room but the call bell was not audible or visible at the display panel to alert staff the call bell was activated. The RN went to the head of the bed, deactivated and reactivated the call bell and confirmed the call bell was not audible or visible. The RN

indicated he/she was unaware that the call bell system was not working until the concern was brought to his/her attention by the inspector. The RN and inspector checked three other rooms in the home area, and the RN confirmed the call bells were not functioning as normal and indicated she was not informed by staff or had noticed the call bells where not functioning on the unit. The RN indicated Information Technology (IT) monitors the call bells and if there is a problem identified they would call IT and the unit manager to inform them of the concern.

Interviews conducted with Personal Support Worker (PSW) staff #102, 103, 104, 105, and 106, indicated if the call bell is activated it can be seen on the ceiling call bell display panel at the end of the halls, is heard, and staff will answer the call bell. The PSWs indicated they use the call bell when they need assistance from another PSW and if the call bells are not functioning staff are unaware if a resident, family, or PSW was calling for assistance. The PSW staff indicated they were unaware the call bell system was not functioning.

An interview with LTCD #101 indicated that when activated at the bedside or washroom, the call bell is audible and the hallway panel display indicates the room and area in which it was activated. LTCD #101 and inspector checked all resident rooms on the identified home area and LTCD #101 acknowledged the call bell system for the whole unit was not functioning. LTCD #101 indicated there was no auditing system in place to ensure the call bells on the unit are functioning. LCTD #101 further indicated that IT is responsible for maintaining the call bell system and he/she was not alerted by the unit staff that the call bell system was not functioning. LTCD #101 indicated that RN #100 had informed him/her of the inspectors' observations. LTCD #101 indicated he/she would call IT and inform the Director of Care and Resident Experience (DOC).

Once the call bell system was identified by the inspector, confirmed by RN #100 and LTCD #101 as not functioning on the identified date, an overhead page for "Code Grey Call Bell System Apotex" was called, indicating the call bell system was down five times in a two and a half hour period.

Interviews with DOC #108 and Associate Director of Care (ADOC) #139 acknowledged the identified home area's call bell system was not functioning and indicated LTCD #101 had informed them of the inspector's observations. The ADOC indicated he/she was aware call bells on another home area were not functioning earlier that day and was fixed shortly after but was unaware the call bells on the above mentioned identified home area were not functioning.

The severity of this non-compliance was identified as potential for actual harm. The scope of the non-compliance was identified as widespread. A review of the home's compliance history revealed that the home was not issued previous noncompliance related to O. Reg. 79/10, r. 17. (1) (b). The inspector conducted stage one resident observation for resident #001 when the inspector identified the call bell system was not functioning. An audit was carried out on 27 resident rooms on the identified home area with LTCD #101 and the call bell system was found to be not functioning. The staff were unaware the call bell system was not functioning until it was identified by the inspector during his/her resident observations. As a result of the severity and scope of this noncompliance a compliance order is warranted. [s. 17. (1) (b)]

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act.

Resident #005 was triggered for skin and wound care through MDS assessment data.

As required by the Regulation (O. Reg. 79/10, s. 30 (1) 1.), in respect to interdisciplinary

skin and wound care program required by the Regulation (O. Reg. 79/10, s. 48 (1) 2.) the Licensee shall ensure that there is a written description of the program that includes its goals and objectives and relevant policies procedures and protocols.

The home's policy titled "Prevention, Assessment and Management of Pressure Ulcers", with a revised date of November 2014, under Physician/Prescriber/Nurse Practitioners under bullet number three states they will order treatment and other interventions for prevention of skin breakdown and management of pressure ulcers. Bullet number eight of the policy indicates that the nurses (RN and RPN) are to carry out the prescribed orders for treatment of pressure ulcers.

A review of the current physician orders revealed a treatment for an area of impaired skin integrity for resident #005. The order indicated the treatment was to be administered every two days (q2days).

A review of the current paper copy of the Medication Administration Record (MAR) from an identified one month period, was carried out by the inspector. The MAR consisted of a treatment order for the area of impaired skin integrity, as indicated above. A review of the MAR failed to reveal signatures for eight identified dates in the one month period.Review of resident #005's progress notes failed to reveal notes to show evidence that the treatment was carried out as ordered.

An interview conducted with RN #126 indicated it was the home's expectation if an MD provided an order for medication or treatment the order was transcribed to the paper MAR by the nurse receiving the order and then the order is to be carried out as prescribed and the nurse is to sign for the order as carried out or a progress note is to be entered in the residents' chart. The RN reviewed the MD order and the paper MAR for the above mentioned identified month period, and progress notes for resident #005's area of impaired skin integrity and the RN acknowledged there were no progress notes or signatures in the TAR indicating that the treatments were carried out on the dates indicated above.

Interviews were conducted with the ADOC #139 and LTCD #140. The ADOC and LTCD indicated it was the home's expectation that when an MD or anyone who is able to prescribe medication or treatments the order is transcribed to the paper MAR by the receiving nurse and the order is to be carried out and signed as being done. The ADOC and LTCD reviewed the identified month's paper MAR for resident #005's impaired skin integrity treatment and acknowledged there were no signatures for the eight dates

indicated above as the treatment being carried out by the registered staff. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the policy of the skin and wound care program that the licensee is required by the Regulation to have instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked to prevent unsupervised access when they were not supervised by staff.

Observations by the inspector on an identified home area during the initial tour of the home on an identified date, revealed an identified door which was equipped with a numbered keypad lock was able to be opened without using the keypad code. Observation revealed a paper napkin had been inserted into the lock mechanism preventing the door from securely locking. Observation inside the identified room revealed a large bin for soiled linen, as well as a large bin for garbage. Observation failed to reveal a call bell located within this room.

In interviews, PSW #135 and RPN #113 stated that the door was difficult to open and had been reported to the maintenance department to look at the door lock. RPN #113 stated that this door should remain locked at all times as there is a wandering resident on the unit.

Observations by the inspector on another identified home area during the initial tour of the home revealed an identified door which was equipped with a numbered keypad lock was able to be opened without using the keypad code. Observation revealed a paper napkin had been inserted into the lock mechanism preventing the door from securely locking. Observation inside the identified room revealed a large bin for soiled linen, as well as a large bin for garbage. Observation failed to reveal a call bell located within this room. In an interview, PSW #136 stated that residents do not have access to this soiled linen and garbage room and the door should be kept locked.

Observation by the inspector two weeks later, on the second above identified home area revealed that the identified door was able to be opened without entering the code on the keypad lock. The door locked when the inspector closed the door fully, and this observation was reported to the DOC.

In an interview, the DOC stated that the soiled linen and garbage rooms on each floor are not to be accessed by residents unsupervised. The DOC stated that the expectation of the home was for these doors to remain locked at all times when not supervised by staff. The DOC acknowledged that the licensee had failed to ensure that all doors leading to non-residential areas were kept closed and locked to prevent unsupervised access when they were not supervised by staff. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that all doors leading to non-residential areas are kept closed and locked to prevent unsupervised access when they are not supervised by staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #005 was triggered for skin and wound care through MDS.

The home's policy titled "Prevention, Assessment and Management of Pressure Ulcers", revised November 2014, under "Early Risk Assessment and Reassessment" states for

patients with existing ulcers, comprehensive assessment (including local wound assessment) will be performed initially, followed by a reassessment at a minimum of weekly to determine wound progress and effectiveness of treatment plan.

A documentation review of resident #005’s patient care notes revealed a progress note from an identified date, carried out by RN #126. The note indicated the RN identified a an area of impaired skin integrity. A skin assessment was carried out, note left for physician, physiotherapy to reassess, and identified treatment protocol put in place.

A review of the “Assessment Form” section revealed a skin assessment and treatment, which was carried out by RN #126 on the above mentioned identified date. Further review of the “Assessment Form” for the area of impaired skin integrity was not assessed weekly by registered nursing staff. The next skin assessment for the identified area was dated 46 days later, which indicated the area of impaired skin integrity remained.

A review of resident #005’s chart revealed an order by the physician one day after the area of impaired skin integrity was identified, which provided for an identified treatment protocol to be put in place.

An interview conducted with RN #126; who was wound lead for the resident #005's home area, indicated that it was the home’s expectation if a resident was identified with an alteration in skin integrity the responsible RN or RPN is to carry out a weekly skin assessment on an identified shift each week. The RN acknowledged he/she carried out the initial skin assessment for resident #005’s area of impaired skin integrity. The RN stated the expectation going forward was that the RN or RPN working the identified shift each week is to carry out a skin assessment on resident #005’s area of impaired skin integrity and document it in the assessment or resident notes. The RN reviewed the "Assessment Form” and reviewed the skin assessments and dates and indicated after his/her initial skin assessment on the above mentioned identified date, with the next skin assessment forty-six days later. The RN went on to the “Patient Care” notes and indicated there were no notes or assessment a one month period for resident #005’sarea of impaired skin integrity. The RN stated weekly skin assessments were not carried out for resident #005 after the resident was identified to have alteration of his/her skin.

Interviews were conducted with the ADOC #139 and LTCD #140. The ADOC and LTCD indicated it was the home’s expectation when a resident was identified as having alteration of skin integrity that nurse was to assess the site and carry out weekly skin assessment and document the assessment on Meditech. The ADOC and LTCD were

provided with resident #005's skin assessment record dates which started on the date the area of impaired skin integrity was identified, both acknowledged that the next assessment was documented 46 days later, and weekly altered skin integrity assessments for resident #005's area of identified altered skin integrity were not carried out. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that residents exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

Issued on this 20th day of December, 2017

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

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ADAM DICKEY (643), SHIHANA RUMZI (604)
Inspection No. / No de l'inspection :	2017_420643_0021
Log No. / No de registre :	025111-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 15, 2017
Licensee / Titulaire de permis :	THE JEWISH HOME FOR THE AGED 3560 BATHURST STREET, NORTH YORK, ON, M6A-2E1
LTC Home / Foyer de SLD :	THE JEWISH HOME FOR THE AGED (2824) 3560 BATHURST STREET, NORTH YORK, ON, M6A-2E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Derrick Bernardo

To THE JEWISH HOME FOR THE AGED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

Upon receipt of this compliance order the licensee shall prepare, submit and implement a plan which includes but is not limited to:
1. Developing and implementing an auditing process to ensure the resident-staff communication and response system is functioning on all units at all times.
2. Maintain a record of audits completed for review upon request.
Please submit the plan to Shihana.rumzi@ontario.ca by January 4, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident-staff communication and response system was on at all times.

During stage one observations, on an identified home area, in the room of resident #001, the inspector observed the following:
-The bed room call bell was activated by the inspector through the call bell panel located at the head of the bed. The inspector observed outside the room on the left upper wall a green light flashed indicating the call bell was activated.
-The washroom call bell was activated, and outside the room on the left upper wall a red light flashed indicating the call bell was activated.

In both cases when the call bells were activated the call bells were not audible and ceiling call bell display panel "Austco" screen did not display the location of the call bells.

An interview conducted with Registered Nurse (RN) #100, indicated when a call bell is activated it sounds and is displayed on the ceiling call bell display panel. The inspector and RN went to resident #001's room, the RN indicated the red and green light was lit outside the room but the call bell was not audible or visible at the display panel to alert staff the call bell was activated. The RN went to the head of the bed, deactivated and reactivated the call bell and confirmed the call bell was not audible or visible. The RN indicated he/she was unaware that the call bell system was not working until the concern was brought to his/her attention by the inspector. The RN and inspector checked three other rooms in the home area, and the RN confirmed the call bells were not functioning as normal and indicated she was not informed by staff or had noticed the call bells where not functioning on the unit. The RN indicated Information Technology (IT) monitors the call bells and if there is a problem identified they would call IT and the unit manager to inform them of the concern.

Interviews conducted with Personal Support Worker (PSW) staff #102, 103, 104, 105, and 106, indicated if the call bell is activated it can be seen on the ceiling call bell display panel at the end of the halls, is heard, and staff will answer the call bell. The PSWs indicated they use the call bell when they need assistance from another PSW and if the call bells are not functioning staff are unaware if a resident, family, or PSW was calling for assistance. The PSW staff indicated they were unaware the call bell system was not functioning.

An interview with LTCD #101 indicated that when activated at the bedside or washroom, the call bell is audible and the hallway panel display indicates the room and area in which it was activated. LTCD #101 and inspector checked all resident rooms on the identified home area and LTCD #101 acknowledged the call bell system for the whole unit was not functioning. LTCD #101 indicated there was no auditing system in place to ensure the call bells on the unit are functioning. LCTD #101 further indicated that IT is responsible for maintaining the call bell system and he/she was not alerted by the unit staff that the call bell system was not functioning. LTCD #101 indicated that RN #100 had informed him/her of the inspectors' observations. LTCD #101 indicated he/she would call IT and inform the Director of Care and Resident Experience (DOC).

Once the call bell system was identified by the inspector, confirmed by RN #100 and LTCD #101 as not functioning on the identified date, an overhead page for "Code Grey Call Bell System Apotex" was called, indicating the call bell system was down five times in a two and a half hour period.

Interviews with DOC #108 and Associate Director of Care (ADOC) #139 acknowledged the identified home area's call bell system was not functioning and indicated LTCD #101 had informed them of the inspector's observations. The ADOC indicated he/she was aware call bells on another home area were not functioning earlier that day and was fixed shortly after but was unaware the call bells on the above mentioned identified home area were not functioning.

The severity of this non-compliance was identified as potential for actual harm. The scope of the non-compliance was identified as widespread. A review of the home's compliance history revealed that the home was not issued previous noncompliance related to O. Reg. 79/10, r. 17. (1) (b). The inspector conducted stage one resident observation for resident #001 when the inspector identified the call bell system was not functioning. An audit was carried out on 27 resident rooms on the identified home area with LTCD #101 and the call bell system was found to be not functioning. The staff were unaware the call bell system was not functioning until it was identified by the inspector during his/her resident observations. As a result of the severity and scope of this noncompliance a compliance order is warranted. [s. 17. (1) (b)] (604)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2018

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

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 15th day of December, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Adam Dickey

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