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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Dec 03, 2015;	2015_246196_0011 (A1)	015787-15	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.2) LP
c/o Southbridge Care Homes 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

BIRCHWOOD TERRACE
237 Lakeview Drive R. R. #1 KENORA ON P9N 4J7

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

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LAUREN TENHUNEN (196) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Please see the attached amended inspection report and orders. Resident identification number #021 changed to the correct number of #005 in Compliance Order #003 and in the Licensee report under s.6(7), finding number three.

Issued on this 7 day of December 2015 (A1)

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

Original report signed by the inspector.

Ontario

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

LAUREN TENHUNEN (196) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): July 6, 7, 8, 9, 10, 13, 14, 15, 16, 17, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), RAI Coordinator, Office Manager, Registered Dietitian (RD), Program Manager/Volunteer Coordinator, Resident Services Counsellor, Environmental Services Manager (ESM), Dietary Aides (DA), Housekeeping staff, Residents and family members.

During the course of inspection, the inspectors conducted a walk through of all resident care areas, observed the provision of care and services to residents, reviewed the health care records of several residents, and reviewed various home policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Safe and Secure Home

Skin and Wound Care

Snack Observation

Sufficient Staffing

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

19 WN(s)
8 VPC(s)
5 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed

and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an indep

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

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to be treated with courtesy and

respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

On a particular day during the inspection, S#100 approached resident #040 and Inspector #616 walking toward the dining room for lunch service and made a disrespectful statement regarding the resident and then proceeded to assist this resident by pushing them in their wheelchair.

S#101 was heard to make a comment in a loud manner over the heads of residents as they were serving plates, when resident #040 was announced by a coworker as being in the dining room for lunch service. This staff was observed to have no interaction with resident #040 for the duration of resident's stay in the dining room. [s. 3. (1)]

2. On a particular day, during the inspection, Inspector #196 observed two staff members at a table in the dining room talking across the table to each other and not engaged in discussion with residents as they assisted with feeding the residents. Staff member S#102 identified the staff as S#103 and S#104 and overheard the staff member's discussion regarding personal concerns. [s. 3. (1) 1.]

3. During an interview with resident #025 by Inspector #577, on a day during the inspection, the resident reported two incidents of staff to resident interactions that were disrespectful. Resident reported to inspector that they didn't report either incident. Inspector further spoke with the DOC concerning resident #025's complaints, and the DOC confirmed that these incidents were not reported. [s. 3. (1) 1.]

4. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to live in a safe and clean environment.

During the inspection, resident #023's room, was observed to have a build up of dirt, debris and wax along the baseboard edges. An interview was conducted with S#105 and they reported that they can't get all the rooms done every day as they are not allowed to take the cart through the dining area during lunch service. When questioned regarding the wax buildup on the floor, they reported that the two resident rooms at the end of the hall, had not had the floor wax completed as there had been an outbreak and all the rooms couldn't be done, but they were planning to get it done this fall when the temperature was cooler.

An interview was conducted with the Environmental Services Manager (ESM) and resident #023's room was observed. The buildup of wax, dirt and debris along the baseboard and floor edges, under the heater, on the heater, the sticky floor and stained toilet were confirmed and discussed. The ESM reported to the inspector that a special mop was purchased that would help remove the buildup, stains in the shared toilet were not removable, except to change the toilet itself and this was one of the two rooms that were not stripped and waxed the last year due to an outbreak.

Resident #023's right to live in a clean environment was not fully respected and promoted.[s. 3. (1) 5.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 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. (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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

Resident #040 was observed to have a front-facing seat belt fastened in place on their wheelchair on a particular day during the inspection. At that time, they demonstrated the
ability to independently unfasten the seat belt.

The current care plan referenced the resident's cognitive status. There was no documentation related to use of the seat belt located throughout resident's care plan.

Interviews with S#107 and S#108 confirmed resident's independent fastening and releasing front-facing seat belt while in wheelchair. [s. 6. (1) (a)]

2. On a particular day during the inspection, resident #002 was observed seated in a wheelchair with a seat belt in place along the top of their thighs. An interview was conducted with resident #002 and they reported to the inspector that they were able to undo the seat belt and that it was used for a specific reason.

According to S#100, resident #002 had a lap belt in place for a specific reason and that it should be used at all times.

The current care plan was reviewed and did not include the intervention of a lap belt as was confirmed through discussion with the Director of Care (DOC).[s. 6. (1) (a)]

3. The licensee has failed to ensure that there was a written plan of care for each resident that set out, clear directions to staff and others who provide direct care to the resident.

During the inspection, Inspector #577 reviewed resident #025's plan of care, which indicated that they receive a specific type of analgesia for pain. Inspector reviewed the resident's current pain orders and Medication Administration Records (MAR), which indicated that this resident receives a different type of analgesia for pain.

The plan of care for resident #025 did not provide clear directions to staff regarding the resident's pain medication. [s. 6. (1) (c)]

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

A Critical Incident System report was submitted to the Director for a resident safety concern incident. According to the report, resident #005, had eloped from the home. A prior elopement had occurred in which staff were able to locate the resident outside the home and persuade them to return.

The care plan that was in effect at the time of the incident was reviewed and included interventions related to behaviours including elopement.

Interviews were conducted with S#100 and S#109 and they reported that resident #005 was identified as having elopement concerns and S#100 also reported that there was a list posted in the medication room on the unit for registered staff to see.

On a particular day in 2015, a registered staff member had observed resident #005 outside of the home despite having concerns with elopement.

5. On a specific day during the inspection, resident #023 was observed lying in bed on their back with bilateral bed rails elevated and on another day, the resident was

observed lying in bed sleeping with bilateral bed rails elevated and the bed was not in its lowest position.

The health care record for resident #023 was reviewed for information regarding the use of bed rails while in bed. The current care plan, under the two different foci identified the use of one bed rail elevated.

Resident #023 was observed on two occasions to be lying in bed with bilateral bed rails elevated despite the plan specifying the use of one bed rail. According to S#116, the staff were in the process of re-evaluating the bed rail use for this resident and the "bed rail decision tree" had not yet been completed. [s. 6. (7)]

6. On a specific day during the inspection, resident #023 was observed seated in their wheelchair at their bedside and upon seeing the inspector they asked to go to bed. The resident told the inspector that they were unable to reach the call bell and pointed to the wall between the two beds. S#110 was informed that the call bell was not within reach of the resident and that they had wanted to get into bed.

On another day, resident #023 was again observed seated in their wheelchair at their bedside, call bell out of reach and hanging from the wall between the two beds, emesis was on the floor. Inspector #196 brought this information to the attention of staff at that time in order to attend to the resident.

On another day, inspector spoke with resident #023 at their bedside. The call bell was observed to be out of the reach of the resident, hanging down from the wall between the two beds. Discussion with the DOC was held at that time and they were informed of the concern with resident #023's call bell being out of reach and inaccessible to the resident.

The current care plan was reviewed and under one of the foci the intervention of having the call bell within reach and clipped to the bed at all times was identified.

On three separate occasions, the call bell for resident #023 was not accessible to the resident and was hanging from the wall between the beds. [s. 6. (7)]

7. The licensee had failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #002 reported to Inspector #196 that they had a particular type of pain in a specific area of their body.

The most recent Medication Administration Record (MAR) and orders were reviewed and included three different medication with specific dosages used to address the particular type of pain.

The current care plan under the area of pain, did not include the current dosages of the medication and instead had the previous amounts listed. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 002, 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 #3: 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 home was equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times.

On a particular day, the call bell cord was hanging off the wall and not within reach of resident #002 as they sat in their wheelchair at the bedside. The resident reported to the inspector that they tell the staff to clip the call bell to the pillow and then they can pull it across the bed while up in the wheelchair and use it. [s. 17. (1) (a)]

2. During the inspection, on a particular day, resident #023 was observed seated in their wheelchair at their bedside and upon seeing the inspector they asked to go to bed. The resident told the inspector that they were unable to reach the call bell and pointed to the wall between the two beds. S#110 was informed that the call bell was not within reach of the resident and that they had wanted to get into bed.

On another day during the inspection, resident #023 was again observed seated in their wheelchair at their bedside, call bell out of reach and hanging from the wall between the two beds, emesis was on the floor. This was brought to the attention of staff at that time to attend to the resident.

On another day during the inspection, inspector spoke with resident #023 at their bedside. The call bell was observed to be out of the reach of the resident, hanging down from the wall between the two beds. Discussion with the DOC was held at that time and they were informed of the concern with resident #023's call bell being out of reach and inaccessible to the resident. [s. 17. (1) (a)]

3. On a day during the inspection, Inspector #577 made the following observations concerning the inaccessibility of resident call bells within the home:
-Resident #032 did not have a call bell cord at their bedside
-Resident #031's call bell cord in the bathroom was two inches in length and not within reach
-Resident #034's call bell in the bathroom was not within reach and wrapped on high shelf on the bathroom wall
-Resident #033's bedside call bell was on the floor, not within reach

Four resident call bells were inaccessible on a particular day of the inspection. [s. 17. (1) (a)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, a person who has reasonable grounds to suspect that any of the following has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Progress notes for resident #045 were reviewed by Inspector #616 and on a particular date, the documentation indicated family concerns had been received that were forwarded to the DOC and EDC (Executive Director of Care).

The inspector interviewed the Administrator regarding the family's concern. They stated they were aware that the DOC had spoken with the family member and reported to the inspector they had no record of the concern.

The DOC confirmed to the inspector, their knowledge of the family's concern of staff to resident abuse although reported that the family was unable to provide staff names to them. In addition, the DOC could not recall whether they had interviewed or followed up with the resident involved in the allegations nor could they produce any documentation regarding this incident to verify the allegations of abuse.

The DOC confirmed to the inspector that they had not notified the Director of allegations of staff to resident abuse. [s. 24. (1) 2.]

Additional Required Actions:

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

WN #5: 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 the following that the licensee knows of, or that is reported to the licensee, was immediately investigated: abuse of a resident by anyone.

Progress notes for resident #045 were reviewed by Inspector #616 and on a particular date the documentation indicated family concerns had been received that were forwarded to the DOC and EDC (Executive Director of Care).

The inspector interviewed the Administrator regarding the family's concern. They stated they were aware that the DOC had spoken with the family member and reported to the inspector they had no record of the concern.

The DOC confirmed to the inspector, their knowledge of the family's concern of staff to resident abuse although reported that the family was unable to provide staff names to them. In addition, the DOC could not recall whether they had interviewed or followed up with the resident involved in the allegations nor could they produce any documentation regarding this incident to verify the allegations of abuse had been investigated and responded to appropriately. [s. 23. (1) (a) (i)]

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 that ensures that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: abuse of a resident by anyone, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, mouth care in the morning and evening, including the cleaning of dentures.

On a particular day during the inspection, resident #021 was observed to have a heavy plaque buildup along their upper anterior teeth, reddened gum tissue and a strong, foul mouth odour. The resident reported that they were tired of asking the staff to brush their teeth for them as they were unable to do so themselves.

The health care record for resident #021 was reviewed and the current care plan included information regarding mouth care and the need for staff assistance with mouth care. The flow sheets for a five day period, were reviewed and the provision of oral care by either the resident or the staff member was not documented on any shift.

An interview was conducted with S#100 and they reported that resident #021 required total assistance with personal care including oral hygiene.

Resident #021 had not received oral care on a particular day, to maintain the integrity of their oral tissue including, mouth care in the morning and evening, as reported by the resident and as evidenced by the condition of the oral cavity. [s. 34. (1) (a)]

2. The licensee has failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required.

During a resident interview, resident #026 complained of tooth pain.

During the inspection, Inspector #577 spoke with S#102 and the DOC, who both reported that the home did not have a dentist that comes into the home and they do not offer all residents an opportunity to see a dentist in the community, subject to payment. S#102 reported that the physician may refer a resident to a dentist if they assess the resident to have any dental issues and staff will arrange with the resident's family. [s. 34. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, mouth care in the morning and evening, including the cleaning of dentures, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

During the inspection, Inspector #616 made observations of unlabelled personal items in the shared washrooms of the following residents:
• Resident #029's - unlabelled shampoo, deodorant, two toothbrushes and toothpaste in one k-basin on the washroom counter.
• Resident #045's - unlabelled hair comb, placed in labelled brush, two toothbrush containers: one white, one blue unlabelled.
• Resident #047's - unlabelled black comb on dresser, unlabelled electric shaver on shared washroom counter, unlabelled blue toothbrush on counter beside sink. Unlabelled second urinal on counter near toothbrush. Room is shared. [s. 37. (1)]

2. During the initial tour of the home, Inspector #577 noted an unclean, unlabelled black hair comb with strands of dark hair sitting on the sink in the tub room and another unclean, unlabelled black comb with visible hair and debris on the sink in the second tub room on one of the units.

In addition, Inspector noted two urinals on the sink in the shared bathroom. Also there was one urinal and one toothbrush, both unlabelled, and on the bathroom counter.

Inspector spoke with S#111, who reported that resident names are always written on their urinals. [s. 37. (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 that ensures each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled with 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 47. Qualifications of personal support workers

Specifically failed to comply with the following:

s. 47. (1) Every licensee of a long-term care home shall ensure that on and after the first anniversary of the coming into force of this section, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, has successfully completed a personal support worker program that meets the requirements in subsection (2). O. Reg. 79/10, s. 47 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that on and after the first anniversary of the coming into force of this section, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, has successfully completed a personal support worker program that meets the requirements in subsection (2).

Inspector #616 spoke with S#112 and they reported that they were a nurses' aide and planned to attend college in the Personal Support Worker (PSW) program in the Fall of 2015.

The Administrator reported to Inspector #196 that all PSWs/HCAs that are employed in the home are certified or have been "grandfathered in" prior to the change in the legislation. When questioned about S#112 and their qualifications, the Administrator reported that they were qualified, and that this staff member was currently enrolled in the PSW program, and thought this was okay to hire them if currently enrolled in the program. The Administrator then reported that two additional staff, on the PSW/HCA schedule, were also working as PSWs and were enrolled to start the PSW program in the Fall 2015.

An interview was conducted with the DOC and it was reported that three staff have been working in the home as PSWs, they are enrolled to start the PSW college program and would either take a leave of absence during the program or would work in the role of a PSW while taking the courses. In addition, the DOC reported they were under the understanding that as long as these staff were enrolled in the program it was alright to be employed as a PSW. The staff included were S#103 and S#112.

The licensee had hired three persons to work in the role as a personal support worker (PSW) and to provide personal support services, and they had not met the requirements. [s. 47. (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 that ensures every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, has successfully completed a personal support worker program that meets the requirements in subsection (2), to be implemented voluntarily.

WN #9: 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, if clinically indicated.

During a record review, Inspector #577 found that resident #029 was admitted in 2015 with altered skin integrity which worsened within a period of approximately six weeks. A progress note, a few months later, indicated that the resident's altered skin integrity had further worsened.

Inspector #577 spoke with S#102, who indicated that resident #029's altered skin integrity treatment on admission was ordered to be done every other day and the orders were changed to daily, approximately six weeks after that time. The current care plan indicated that the altered skin integrity treatment was to be done daily.

On a day during the inspection, Inspector #577 reviewed the altered skin integrity records for resident #029.

The inspector spoke with the DOC, who indicated that the wound care record was considered the home's weekly wound assessment and it was required to be documented on once weekly.

The altered skin integrity records indicated that there were significant lapses of time, greater than one week, where resident #029's skin issue was not assessed on a weekly basis. [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 that ensures a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #10: 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 has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: A change of 5 per cent of body weight, or more, over one month.

Inspector reviewed resident #040's census record for their weights that are obtained monthly which indicated: a weight difference of 3.2kg was calculated over a one month period resulting in a change of five per cent of body weight.

In an interview with Registered Dietitian (RD, they confirmed the weight loss calculation of 5.26% for the resident in one month period. The RD confirmed they did not assess the resident's weight change with actions taken and outcomes evaluated.

S#114 reported they were unaware of resident #040's weight change of greater than five percent as they did not receive a staff referral, nor did the weight change alert as per normal practice when values are outside the parameters for the electronic program in the resident's health care record. [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 that ensures residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: A change of 5 per cent of body weight, or more, over one month, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The shared washroom in a resident room was observed to have a container of prescription cream, labelled with resident #048's name. This was brought to the attention of S#100 at and they reported that PSWs do apply topical medications but they should not be left in the residents' rooms/washrooms. [s. 129. (1) (a) (ii)]

2. A plastic bag was observed with several containers of prescription topical medications inside, placed on top of a resident care cart at the end of one of the corridors. This was brought to the attention of S#120 and they confirmed that the medication creams should be kept in the locked clean utility room and not in the hallway on the cart. The topical prescription medications included:
- Resident #052 - one cream
- Resident #053 - two creams
- Resident #022 - one lotion, one cream
- Resident #029 - one cream
- Resident #047 - one cream
[s. 129. (1) (a) (ii)]

3. A prescription cream was observed on resident #026's bed.

S#115 confirmed that the medication was supposed to be returned to the medication cart when care was completed. [s. 129. (1) (a) (ii)]

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 that ensures drugs are stored in an area or a medication cart, that is secure and locked, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

On a particular day during the inspection, the health care records for resident #025 were reviewed by Inspector #577.

The pain assessment completed on a particular day, indicated that this resident had

pain and it went on to identify the type and description, location and number on a pain scale as well as what helped to relieve it.

The Medication Administration Records (MAR) for a three month period in 2015, identified that this resident received analgesic medication on one of the days.

Inspector reviewed residents progress notes and treatment notes and neither had a documented response to the effectiveness of the pain medication given. [s. 134. (a)]

2. During the inspection, resident #021 reported to the inspector that a specific part of their body was sore all the time.

The health care records for resident #021 were reviewed and the Medication Record Administration (MAR) identified the use of analgesia, regular dosing three times daily and there were no PRN (as necessary) medications ordered. The pain assessment done online did not identify any pain and did not have any of the assessment categories completed, including pain "history" and "medication" despite resident #021 receiving regular dosing of analgesia three times daily. The "pain flow record" as found in the MAR book was reviewed and the most recent assessment of pain, pre and post analgesia administration was completed in spring 2014.

On a day during the inspection, an interview was conducted with S#100 and they reported that resident #021 had no pain concerns and they were unaware of specific areas of pain but that they did have an area of pain when first admitted to the home. S#116 reported that the resident was on regular analgesia dose and that the resident was doing well with pain management.

Resident #021 was receiving a regular scheduled dose of analgesia for pain yet the most recent pain assessment and the pain flow records did not include the monitoring and documentation of this resident's response and the effectiveness of the analgesia. [s. 134. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #13: 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 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, is in compliance with and is implemented in accordance with applicable requirements under the Act.

The O.Reg.79/10,s.122.(1)(b), reads "Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131(7) unless the drug, has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario.

During the inspection, Inspector #577 reviewed the home's policy "Family supplied medicinal products", dated September 2010. The policy identified that "where there is insistence that family supply a medicinal product for a resident, the following process is to be followed: the product must be labelled with the resident name, date of birth and directions for use". The home's policy is outdated and not in compliance with the current legislation, specifically, O.Reg.79/10,s.122(1)(b). [s. 8. (1) (a)]

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

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

Findings/Faits saillants :

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

On a specific day, resident #029's bed was observed with both bed rails in the up position and resident was not present at the time.

An interview was conducted with resident #029 regarding the bed rails. They reported that they prefer both bed rails in the up position when in bed for fear of falling and added that when they are in bed, they cannot undo the bed rails when engaged in up position.

The licensee's Physical Restraints policy #RESI-10-01-01, dated November 2012, provided by the Administrator, indicated approved physical restraints include bed side rails and noted that a resident is considered to be restrained with the use of side rails if: full or 3/4 are used on both open sides of their bed. The policy further noted a written order for a physical restraint must include the type of restraint to be used, when the restraint may be used, and how long the restraint may be used for.

The health care record for resident #029 was reviewed, which included the physician's orders, assessments, progress notes, falls history, and the care plan.

The health record review from the time of admission to the time of inspection, July 15, 2015, did not produce a bed rail assessment nor a physician's order for the use of two bed rails. As per the MORSE fall scale assessment, the resident had a history of falls and was deemed a "high risk" (score 50). Progress notes from initial admission conference also noted a previous history of falls, and they use bed rails for bed mobility. The care plan indicated the use of two bed rails up at all times while in bed for positioning.

Interviews with S#109 and S#102 confirmed the resident #029's use of two bed rails while in bed. S#102 reported historically, the determination for use of bed rails occurs at the time of resident admission where staff would only use their judgment to assess resident's capability and risks while in bed. They added that the process of bed rail assessments using the decision tree has just been started and was not in place previously. S#102 confirmed there is no bed rail assessment for this resident.

Resident #029 was not assessed and their bed system evaluated in order to minimize risk to the resident. [s. 15. (1) (a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any.

During the inspection, an interview was conducted with a family member of resident #023 and it was reported that they had not been invited to an annual care conference, but they would attend if invited.

In discussion with the DOC, it was determined that the last annual care conference regarding resident #023 was held in the winter of 2013, and that the conference had been scheduled several times in 2014 but due to the resident's family members cancellations, it was not held without them in attendance. [s. 27. (1)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

An interview was conducted with resident #002 and they reported to the inspector that they had a particular type of pain. They described the pain in detail to the inspector and reported that the physician had increased their medication and there was no difference since the increase in medication. In addition, they reported that they never ask for pain medication.

The health care record for resident #002 was reviewed by Inspector #196. The online pain assessment tool identified that the resident expressed verbal or non-verbal signs of pain. The remainder of the assessment was not completed.

An interview was conducted by Inspector #196 with S#100 and they reported that this resident didn't really complain that much about pain, they were not sure why resident #002 was on a specific type of medication and that there was a different type of analgesia ordered when necessary but none had been administered in a particular month. S#116 reported that this resident had difficulty with movement and will complain of discomfort with turning in bed and confirmed to the inspector that the most recent pain assessment done was not complete. S#117 reported to the inspector, that resident #002 does complain of pain from a particular area of their body and as a result staff needed to be more careful with the provision of personal care.

Resident #002, despite continued discomfort and initial interventions, had not been re-assessed using a clinically appropriate assessment instrument, specifically designed for this purpose. [s. 52. (2)]

WN #17: The Licensee has failed to comply with LTCHA, 2007, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that written response is provided to Family Council within 10 days of receiving advice related to concerns or recommendations.

Inspector #616 reviewed the Family Council minutes for the past three council meetings for the months March, April and May 2015 which indicated agenda items that noted the required action/follow up by the home.

In an interview with the Resident Services Coordinator, they reported to inspector that the Family Council agenda items that required action was presented to the administrative team verbally, post-council meeting.

They added there was no follow up written response from administration and shared the action plans verbally with the council at the next scheduled meeting. Interviews with both the DOC and the Administrator, confirmed there was no written responses provided to Family Council within 10 days of receiving concerns or recommendations. [s. 60. (2)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter.

Height documentation was obtained from the electronic health records for the following residents which identified their height was not measured annually:

Resident #047, Resident #050, Resident #046, Resident #041, Resident #051,

S#102 reported to the inspector that resident height measurements are obtained on admission and would be documented by staff in the resident's electronic health record. [s. 68. (2) (e) (ii)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is acquired, received or stored by or in the home or kept by a resident that has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario.

On a day during the inspection, Inspector #577 noted a bottle of over-the-counter vitamin supplement in the bottom drawer of the medication cart. S#102 and S#119 both reported that the vitamin supplement was prescribed for resident #029, which their family brought in and staff are administering.

Inspector reviewed Resident #029's medication administration record (MAR) which indicated that this resident was currently prescribed this vitamin supplement, 5ml daily and the supplement was given on several days.

The vitamin supplement ordered for use by resident #029 was not provided by the home's pharmacy service provider and instead supplied by the resident's family. [s. 122. (1)]

Issued on this 7 day of December 2015 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Sudbury Service Area Office
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LAUREN TENHUNEN (196) - (A1)

Inspection No. / No de l'inspection : 2015_246196_0011 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 015787-15 (A1)

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

Report Date(s) / Date(s) du Rapport : Dec 03, 2015;(A1)

Licensee / Titulaire de permis :
CVH (No.2) LP
c/o Southbridge Care Homes, 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8

LTC Home / Foyer de SLD :
BIRCHWOOD TERRACE
237 Lakeview Drive, R. R. #1, KENORA, ON, P9N-4J7

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : WENDY SARFI

To CVH (No.2) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or

refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

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

The licensee shall ensure compliance with LTCHA, 2007 S.O. 2007,c.8,s.3. (1)1.,5., whereby the following rights of resident #040, #025, and all other residents are fully respected and promoted:
Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity and every resident has the right to live in a safe and clean environment.

The licensee shall prepare, submit and implement a plan for achieving compliance with s.3.(1)1.,5. of the LTCHA. The plan is to include:
1) Strategies that will ensure that the rights of residents in the home are upheld.
2) Training for all staff regarding the Residents' Bill of Rights.

This compliance plan is due to be submitted by Friday October 9, 2015, to Lauren Tenhunen LTCH Nursing Inspector #196 via email. Implementation and full compliance with the plan is to be achieved by Friday November 6, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

On a particular day during the inspection, S#100 approached resident #040 and Inspector #616 walking toward the dining room for lunch service and made a disrespectful statement regarding the resident and then proceeded to assist this resident by pushing them in their wheelchair.

S# 101 was heard to make a comment in a loud manner over the heads of residents as they were serving plates, when resident #040 was announced by a co-worker as being in the dining room for lunch service. This staff was observed to have no interaction with resident #040 for the duration of resident's stay in the dining room. (616)

2. On a particular day during the inspection, Inspector #196 observed two staff members at a table in the dining room talking across the table to each other and not engaged in discussion with residents as they assisted with feeding the residents. Staff member S#102 identified the staff as S#103 and S#104. The inspector overheard the staff member's discussion regarding personal concerns.

(196)

3. During an interview with resident #025 by Inspector #577, on a day during the inspection, the resident reported two incidents of staff to resident interactions that were disrespectful. Resident reported to inspector that they didn't report either incident. Inspector further spoke with the DOC concerning resident #025's complaints, and the DOC confirmed that these incidents were not reported. (577)

4. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to live in a safe and clean environment.

During the inspection, resident #023's room was observed to have a build up of dirt, debris and wax along the baseboard edges. An interview was conducted with S#105 and they reported that they can't get all the rooms done every day as they are not allowed to take the cart through the dining area during lunch service. When questioned regarding the wax buildup on the floor, they reported that the two resident rooms at the end of the hall, had not had the floor wax completed as there had been an outbreak and all the rooms couldn't be done, but they were planning to get it done this fall when the temperature was cooler.

An interview was conducted with the Environmental Services Manager (ESM) and resident #023's room was observed. The buildup of wax, dirt and debris along the baseboard and floor edges, under the heater, on the heater, the sticky floor and stained toilet were confirmed and discussed. The ESM reported to the inspector that a special mop was purchased that would help remove the buildup, stains in the shared toilet were not removable, except to change the toilet itself and this was one of the two rooms on the 2nd floor that were not stripped and waxed the last year due to an outbreak.

Resident #023's right to live in a clean environment was not fully respected and promoted.

Previous non-compliance specific to LTCHA 2007,S.O.2007,c.8,s.3 was identified during the RQI inspection in August 2014 - inspection # 2014_211106_0014, during a complaint inspection April 2014 - inspection #2014_333577_0005, during a Critical Incident System inspection in May 2013 - inspection #2013_211106_0008.
(196)

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

Nov 06, 2015

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 :

LTCHA, 2007, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure that there is a written plan of care for resident #025, #040 and #002, and all other residents, that sets out, the planned care for the resident and clear directions to staff and others who provide direct care to the resident.

The licensee shall prepare, submit and implement a plan for achieving compliance with s.6.(1)(a)(c) of the LTCHA. The plan is to include:
1) Strategies that will ensure that the written plan of care for residents sets out the planned care and provides clear directions to staff.
2) Training for the staff who develop the resident's plans of care to ensure clear directions are identified for the direct care providers.

This compliance plan is due to be submitted by Friday October 9, 2015, to Lauren Tenhunen LTCH Nursing Inspector #196. Implementation and full compliance with the plan is to be achieved by Friday November 6, 2015.

Grounds / Motifs :

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

On a particular day during the inspection, resident #002 was observed seated in a wheelchair with a seat belt in place along the top of their thighs. An interview was conducted with resident #002 and they reported to the inspector that they were able to undo the seat belt and that it was used for a specific reason.

According to S#100, resident #002 had a lap belt in place for a specific reason and that it should be used at all times.

The current care plan was reviewed and did not include the intervention of a lap belt as was confirmed by the Director of Care (DOC) .

(196)

2. Resident #040 was observed to have a front-facing seat belt fastened in place on their wheelchair on a particular day during the inspection. At that time, they demonstrated the ability to independently unfasten the seat-belt.

The care plan referenced the resident's cognitive status. There was no documentation related to use of the seat belt located throughout resident's care plan.

Interviews with S#107 and S#108 confirmed resident's independent fastening and releasing front-facing seat belt while in wheelchair.
(196)

3. The licensee has failed to ensure that there was a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

During the inspection, Inspector #577 reviewed resident #025's plan of care, which indicated that they receive a specific type of analgesia for pain. Inspector reviewed residents current pain orders and Medication Administration Records (MAR), which indicated that this resident receives a different type of analgesia for pain.

The plan of care for resident #025 did not provide clear directions to staff regarding the resident's pain medication.

Previous non-compliance specific to LTCHA 2007,S.O.2007,c.8,s.6 was identified during the RQI inspection in August 2014 - inspection # 2014_211106_0014, during a Critical Incident System inspection in July 2014 - #2014_211106_0012, during a Complaint inspection in June 2014 - #2014_339579_0010, during a Complaint inspection in April 2014 - #2014_333577_0005, during a Critical Incident System inspection in May 2013 - #2013_211106_0008, during a Complaint inspection in January 2013 - #2013_211106_0001. (577)

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

Nov 06, 2015

Order # /
Ordre no : 003

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

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

(A1)
The licensee shall ensure compliance with LTCHA, 2007, S.O.2007,c.8,s.6. (7), whereby the care set out in the plan of care for resident #021 and #023, is provided to the resident as specified in the plan.

The licensee shall prepare, submit and implement a plan for achieving compliance with s.6.(7) of the LTCHA. The plan is to include:
1) Strategies that will ensure that care set out in resident s plans of care is provided to the residents.
2) Training of staff relating to resident plans of care.

This compliance plan is due to be submitted by Friday October 9, 2015, to Lauren Tenhunen LTCH Nursing Inspector #196 via email at lauren.tenhunen@ontario.ca. Implementation and full compliance with the plan is to be achieved by Friday November 6, 2015.

Grounds / Motifs :

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

On a specific day during the inspection, resident #023 was observed seated in their wheelchair at their bedside and upon seeing the inspector they asked to go to bed. The resident told the inspector that they were unable to reach the call bell and pointed to the wall between the two beds. S#110 was informed that the call bell was not within reach of the resident and that they had wanted to get into bed.

On another day, resident #023 was again observed seated in their wheelchair at their bedside, call bell out of reach and hanging from the wall between the two beds, emesis was on the floor. Inspector #196 brought this information to the attention of staff at that time in order to attend to the resident.

On another day, inspector spoke with resident #023 at their bedside. The call bell was observed to be out of the reach of the resident, hanging down from the wall between the two beds. Discussion with the DOC was held at that time and they were informed of the concern with resident #023's call bell being out of reach and inaccessible to the resident.

The current care plan was reviewed and under one of the foci the intervention of having the call bell within reach and clipped to the bed was identified.

On three separate occasions, the call bell for resident #023 was not accessible to the resident and was hanging from the wall between the beds.

(196)

2. On a specific day during the inspection, resident #023 was observed lying in bed on their back with bilateral full bed rails elevated and on another day, the resident was observed lying in bed sleeping with bilateral full bed rails elevated and the bed was not in its lowest position.

The health care record for resident #023 was reviewed for information regarding the use of bed rails while in bed. The current care plan, under the two different foci identified the use of one bed rail elevated.

Resident #023 was observed on two occasions to be lying in bed with bilateral bed rails elevated despite the plan specifying the use of one bed rail. According to S#116, the staff were in the process of re-evaluating the bed rail use for this resident and the "bed rail decision tree" had not yet been completed.

(196)

(A1)
3. A Critical Incident System report # 2620-000010-15 was submitted to the Director on June 29th, 2015, for a resident missing for greater than three hours. According to the report, resident #005, was last seen sitting outside the home by a registered staff member at 1030hrs on June 29, 2015, and then at 1230hrs could not be located. The resident was returned to the home later that day at approximately 1525hrs. A prior elopement had occurred on April 17, 2015, in which staff were able to locate the resident outside the home and persuade them to return.

The care plan that was in effect at the time of the incident was reviewed and included the focus of "Behaviour: Elopement, exit seeking r t(related to) personal history of alcohol abuse, wants to live back on the street". Interventions included "If he exits the building and will not return than Police will need to be informed" and "Monitor and ensure (resident #005) does not know exit code for the magnetic exit doors".

Interviews were conducted with S#100 and S#109 and they reported that resident #005 was identified as a "flight risk" at the time of the elopement on June 29, 2015. S#100 also reported that there was a "flight risk" list posted in the medication room on the first floor unit for registered staff.

On June 29, 2015, at approximately 1030hrs, a registered staff member had observed resident #005 sitting outside the home despite being identified as at risk for elopement.

Previous non-compliance specific to LTCHA 2007,S.O.2007,c.8,s.6 was identified during the RQI inspection in August 2014 - inspection # 2014_211106_0014, during a Critical Incident System inspection in July 2014 - #2014_211106_0012, during a Complaint inspection in June 2014 - #2014_339579_0010, during a Complaint inspection in April 2014 - #2014_333577_0005, during a Critical Incident System inspection in May 2013 - #2013_211106_0008, during a Complaint inspection in January 2013 - #2013_211106_0001. (196)

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

Nov 06, 2015

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 004

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 :

The licensee shall ensure compliance with O.Reg.79/10, s.17.(1)(a), whereby the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

The licensee shall prepare, submit and implement a plan for achieving compliance that will ensure that the resident-staff communication and response system can be accessed by residents at all times. The plan is to include:
1) Strategies that will ensure staff are providing residents with access to their call bells.
2) Methods to be implemented that will monitor the consistent provision of call bells to the residents in the home.

This compliance plan is due to be submitted by Friday October 9, 2015, to Lauren Tenhunen LTCH Nursing Inspector #196. Implementation and full compliance with the plan is to be achieved by Friday November 6, 2015.

Grounds / Motifs :

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

During the inspection, on a particular day, resident #023 was observed seated in their wheelchair at their bedside and upon seeing the inspector they asked to go to bed. The resident told the inspector that they were unable to reach the call bell and pointed to the wall between the two beds. S#110 member was informed that the call bell was not within reach of the resident and that they had wanted to get into bed.

On another day during the inspection, resident #023 was again observed seated in their wheelchair at their bedside, call bell out of reach and hanging from the wall between the two beds, emesis was on the floor. This was brought to the attention of staff at that time to attend to the resident.

On another day during the inspection, inspector spoke with resident #023 at their bedside. The call bell was observed to be out of the reach of the resident, hanging down from the wall between the two beds. A discussion with the DOC was held at that time and they were informed of the concern with resident #023's call bell being out of reach and inaccessible to the resident.

On three different days, the resident-staff communication and response system, specifically the call bell, was not accessible to resident #023.

(196)

2. On a particular day, the call bell cord was hanging off the wall and not within reach of resident #002 as they sat in their wheelchair at the bedside. The resident reported to the inspector that they tell the staff to clip the call bell to the pillow and then they can pull it across the bed while up in the wheelchair and use it.

(196)

3. On a day during the inspection, Inspector #577 made the following observations concerning the inaccessibility of resident call bells within the home:
-Resident #032 did not have a call bell cord at their bedside
-Resident #031's call bell cord in the bathroom was two inches in length and not within reach
-Resident #034's call bell in the bathroom was not within reach and wrapped on high shelf on the bathroom wall
-Resident #033's bedside call bell was on the floor, not within reach

Four resident call bells were inaccessible on a particular day of the inspection.

(196)

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

Nov 06, 2015

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 : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee shall ensure compliance with LTCHA, 2007 S.O.2007,c.8, s.24. (1)

The licensee shall prepare, submit and implement a plan for achieving compliance with s.24(1) of the LTCHA. The plan is to include:

1) A process is to be developed that will track allegations of abuse to ensure that each incident is reported according to the legislation.

This compliance plan is due to be submitted by Friday October 9, 2015, to Lauren Tenhunen LTCH Nursing Inspector #196 via email.
Implementation and full compliance with the plan is to be achieved by Friday October 16, 2015.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Grounds / Motifs :

1. The licensee failed to ensure that, a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Progress notes for resident #045 were reviewed by Inspector #616 and on a particular date, the documentation indicated family concerns had been received that were forwarded to the DOC and EDC (Executive Director of Care).

The inspector interviewed the Administrator regarding the family's concern. They stated they were aware that the DOC had spoken with the family member and reported to the inspector they had no record of the concern.

The DOC confirmed to the inspector, their knowledge of the family's concern of staff to resident abuse although reported that the family was unable to provide staff names to them. In addition, the DOC could not recall whether they had interviewed or followed up with the resident involved in the allegations nor could they produce any documentation regarding this incident to verify the allegations of abuse.

The DOC confirmed to the inspector that they had not notified the Director of allegations of staff to resident abuse.

Previous non-compliance was identified in a Critical Incident System inspection in July 2014 - 2014_211106_0012, Complaint inspection in April 2014 - 2014_333577_0005, Critical Incident System inspection in May 2013 - 2013_211106_0008. (616)

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

Oct 16, 2015

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 or by fax upon:

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

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

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

Issued on this 7 day of December 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LAUREN TENHUNEN - (A1)

Service Area Office /
Bureau régional de services : Sudbury