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 sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Nov 14, 2018	2018_740621_0023 (A1)	005682-18, 013711-18, 013722-18, 013723-18	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No. 2) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes 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

Amended by JULIE KUORIKOSKI (621) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

The public inspection report #2018_740621_0023 was amended in order to change the compliance order due dates in the public orders report for CO#001, #002, #003 and #004 from February 8, 2019 to March 8, 2019.

Issued on this 14th day of November, 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Amended by JULIE KUORIKOSKI (621) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 10 - 14, and 17 - 21, 2018.

The following additional intakes were inspected during this Resident Quality Inspection:

- One intake for compliance order (CO) #001, issued during inspection #2018_624196_0012, regarding s.8(3) related to 24 hour RN;

- One intake for CO #001, issued during inspection #2018_624196_0011, regarding s.8(1) related to an organized program of Personal Support Services;

- One intake for CO #002, issued during inspection #2018_624196_0012, regarding s.134 related to medication management;

- One Compliant intake related to falls prevention and management;

- One Compliant intake related to staff to resident abuse;

- One Compliant intake related to a resident's medication management, responsive behavior management, plan of care and housekeeping services;

- One Compliant intake related to staff to resident neglect, nursing and personal support services, medication/pain and responsive behavior management, and maintenance services;

- Six Critical Incident (CI) intakes related to falls prevention and management; and

- Two CI intakes related to staff to resident abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Environmental Services Manager (ESM), Program Manager/Volunteer Coordinator (PMVP), Nutrition Manager (NM), Office Manager, Scheduler, Resident Assessment Instrument (RAI) Coordinator, Registered Social Worker (RSW), Registered Dietitian (RD), Physiotherapist (PT), North West Local Health Integrated Network (NWLHIN) Occupational Therapist (OT), Housekeeping Aides, residents and

family members.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident, and resident to resident interactions, reviewed relevant health records, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **25 WN(s)**
- **10 VPC(s)**
- **4 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 134.	CO #002	2018_624196_0012	196
LTCHA, 2007 S.O. 2007, c.8 s. 8. (1)	CO #001	2018_624196_0011	625

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

The licensee has failed to comply with compliance order (CO) #001 from inspection #2018_624196_0012, served on June 1, 2018, with a compliance date of July 31, 2018.

The order required the licensee to ensure the following:
"The licensee must be compliant with the Long-Term Care Homes Act, 2007, c. 8, s. 8 (3)" ; and
The licensee must ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations."

Inspector #625 reviewed nursing staff sign-in sheets for a time period between July and September 2018. On a specific day and shift in August 2018, the sign-in sheet indicated that RN #115, who was an agency RN, had worked as the only RN in the building.

During interviews with Scheduler #116, they stated that RN #115 was an RN employed through a staffing agency, and had been the only RN working in the home during a specific shift on a certain day in August 2018, due to an empty rotation.

During an interview with the Executive Director (ED), they stated that RN #115 had been employed by the home through a staffing agency and had worked alone during a specific shift, on a certain day in August 2018. [s. 8. (3)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, where the LTCHA, 2007 or O. Reg. 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was complied with.

The Long-Term Care Homes Act, 2007, c. 8, s. 21 identifies that every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

During resident interviews, resident's #013 and #014 informed Inspector's #625 and #577 respectively that a specified amount of their money had went missing over a certain period of time.

Inspector #625 reviewed the home's policy titled "Complaints and Customer Service – RC-09-01-04", last updated April 2017, which identified that the home would track and resolve concerns and complaints in a fair and timely manner and take steps to address root causes and contributing factors in order to prevent recurrence. The policy identified that verbal complaints were to have investigations immediately initiated where possible, (i.e., complaints about missing laundry, missing glasses, etc.). The policy also identified that "Appendix 1 - Complaint Investigation Form" was to be completed in detail if the complaint could not be resolved within 24 hours, and forwarded to the Administrator/department manager. The policy further identified that "Appendix 5 - Complaint Log" was to be used to maintain a record of all complaints and actions taken, and the home was to monitor the resolution of concerns/complaints monthly to identify trends and opportunities for quality improvement.

Inspector #625 reviewed the home's completed "Appendix 5 - Complaint Log" for 2018, which identified on a specific day in April 2018, resident #033 had complained that a specified amount of money was missing from their possession. The "Summary of Actions Taken" section of the log identified that the resident was re-educated on the importance of keeping their money locked up in the main office until they needed it to make a purchase. Another complaint from resident #034, related to missing money from another day in April 2018, indicated that the resident believed their roommate had taken a specified amount of money from them. The "Summary of Actions Taken" section of the log identified that the home was unable to determine if resident #034's roommate had taken their money, and resident #034 was educated by the home on ensuring their wallet and money was kept in the office for safe keeping.

During an interview with PSW #118, they stated that they were aware that residents #017 and #035 had reported missing money in 2018, but were not aware that resident #014 had money missing. PSW #118 however, identified that resident #014 was a reliable historian and would be able to keep track of something like that. Further, the PSW stated that when a resident reported money missing, they would look for the money and tell the RN if it could not be found.

During an interview with PSW #112, they stated that resident #036 had reported

that a specific amount of money and a piece of jewellery went missing over a specified period of time. The PSW also stated they had looked for the items, but had not located them, and that they had reported it to a nurse on duty.

During an interview with RPN #106, they stated that when a resident's money was reported missing, they would look for it, fill out a complaint form, and chart on it. The RPN identified that they were not aware that a number of residents including, #013, #014, #017, #033 or #035 had reported missing money, however they stated that they would believe resident #017, as they had a good memory; that resident #013 would know; and that resident #014 would also probably know if their money went missing.

During an interview with RPN #119, they stated that they were aware that resident #013 had reported missing a certain amount of money, and that they had notified the resident's family, who wasn't sure if the resident had that much money with them. The RPN also stated they were not aware that resident #036 had reported money missing over a specific period of time. Further, RPN #119 indicated that when there was a complaint made by a resident of missing money, that they would call the laundry department, complete a chart note, and notify the family. Additionally, RPN #119 identified that when family reported missing money, they would fill out a complaint form and forward it to the Director of Care (DOC). The RPN indicated that residents sometimes went to the main office directly to let the home know of missing money, and as a result staff on the unit would not always know.

During an interview with RN #110, they stated that they would fill out the home's "Complaint Investigation Form" and document in the progress notes of the residents electronic health record, when items including money, were reported missing by residents. RN #110 identified that they knew resident #035 had reported missing money, but could not recall if it was on a shift they had worked on, or if the information had been passed onto them. The RN showed Inspector #625 a binder which contained blank "Complaint Investigation Forms", which the RN stated were to be completed when money was reported missing, with completed forms submitted to the DOC. RN #110 acknowledged that one form dated from 2017, had been only partially completed, which identified a resident was missing a specific amount of money.

During an interview with Scheduler #116, who also handled residents' money, they stated to Inspector #625 that they had heard resident #013 was missing

money as the resident had come down to the office about it.

Inspector #625 reviewed progress notes for resident's #013, #014 and #037, but was unable to locate any documentation related to the issue of missing money being reported by the residents.

Inspector #625 also reviewed progress notes for resident #017 and identified a note from April 26, 2018, by the Registered Social Worker (RSW), which indicated the resident brought up the issue of having lost a specified amount of money over the previous weekend; that the RSW found a hole in the bottom of the resident's money pouch, and proceeded to stitch up the pouch "to ensure no money fell out in the future".

A review of progress notes for resident #035, identified an entry dated from April 2018, which detailed the resident's complaint of missing a specified amount of money; that the resident told one of the staff to put the money in their top drawer; and that the money was not there later that day.

Additionally, a review of progress notes for resident #033, identified an entry dated from a specific day in February 2018, by the RSW, which identified resident #033 spoke to the RSW about a situation where resident #014 accused resident #033 of knowing who had taken the money from their room. The entry further identified that the RSW provided the resident with coping strategies and confirmed that resident #033 had used "good assertiveness skills" to address resident #014's comments.

During an interview with Inspector #625, the DOC stated that they had not received any paper copies of the home's Complaints Investigation Forms in 2018, and specifically identified that they had not received any complaints regarding missing money. The DOC also acknowledged that the home's complaints policy had not been followed by staff with respect to verbal complaints of missing money in the home.

During interviews with Inspector #625, the ED stated that money probably went missing from the home daily and that the home wouldn't do much if it was a small amount. The ED further stated they had not been told of any missing resident money by staff since they assumed the role of ED in the home, and could not locate any additional complaint forms related to missing money, except for what was listed in the home's completed "Appendix 5 – Complaint Log" for 2018. The

ED confirmed that the home's Complaints and Customer Service policy should have been followed for missing money, but that it had not been. [s. 8. (1) (b)]

Additional Required Actions:

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

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written staffing plan for the organized programs of nursing services and personal support services referred to in Ontario Regulation 79/10, s. 31 (1) (a) and (b).

On June 1, 2018, CO #001 from inspection #2018_624196_0011 was served pursuant to the LTCHA, 2007, c. 8, s. 8 (1) (b). Step (b) of the order required the licensee to ensure that there was a written staffing plan for the organized programs of nursing services and personal support services referred to in O. Reg. 79/10, s. 31. (1) (a) and (b), in accordance with O. Reg. 79/10, s. 31 (2). Step (c) of the order required the licensee to ensure that the staffing plan was developed and implemented in consideration of O. Reg. 79/10, s. 31 (3) and (4).

During an interview with Inspector #625, Scheduling Clerk #116 identified that the home had a total of 15 filled and 26 vacant PSW positions. They stated that the usual staffing complement was eight PSWs on the day shift, eight PSWs on the evening shift and four PSWs on the night shift, but that the home had been staffing with fewer PSWs due to the lower occupancy rate. Scheduling Clerk #116 stated that, with the lower occupancy rate, the home was being staffed with seven PSWs on both day and evening shifts.

Inspector #625 reviewed Personal Support Worker (PSW) sign-in sheets for a specific time period between July and September 2018. The sheets identified that the home had employed agency staff to work as PSWs; that agency staff worked 59 out of 60, (or 98 per cent), of the dates reviewed; and the home scheduled up to five agency PSWs to work in one day. The sheets also identified that in spite of regular shifts being eight hours (hrs) in duration, with day shifts occurring from 0700 to 1500 hrs; evening shifts from 1500 to 2300 hrs; and night shifts from 2300 to 0700 hrs, home's staff and agency staff had worked up to 16 hrs on 26 out of 50 days, in order to staff the home, while working with less than the required staff complement.

During an interview, Inspector #625 and the ED reviewed O. Reg. 79/10, s. 31 with a focus on the written staffing plan and the requirements of the plan as per subsections (2) and (3). The ED identified that the home did not have a written staffing plan required pursuant to O. Reg. 31 (2). The ED acknowledged that the home had not completed the written staffing plan and stated that the plan was being developed to include staffing model changes. [s. 31. (2)]

Additional Required Actions:

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

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, without in any way restricting the generality of the duty provided for in section 19, there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

Inspector #625 reviewed the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", last updated April 2017, which indicated that staff were to complete an internal incident report and notify their supervisor of witnessed or suspected abuse or neglect; and management would promptly and objectively report all incidents to external regulatory authorities, including the police if there were reasons to believe a criminal code offence had been committed.

The Inspector also reviewed appendices to the policy including:
(1) "Abuse and Neglect Decision Tree", last updated April 2017, which indicated that "Supervisor immediately reports to the Administrator/DOC/designate", "Notify SDM/POA or and other individual identified by the resident"; and "Proceed to appropriate Ontario LTC decision tree and submit a CIS Report";
(2) "Jurisdictional Reporting Requirements" last updated April 2017, which identified, in Ontario, mandatory reporting required a person to make an immediate report to the Director where there was a reasonable suspicion that certain incidents occurred or may occur, which included "Misuse or misappropriate of a Resident's money";
(3) "Ontario LTC Financial Abuse Decision Tree" last updated April 2017, which identified that, if there were reasonable grounds to suspect that financial abuse had occurred or may have occurred, the licensee was to determine if a resident's money or property was misused or misappropriated. If it was, the licensee was to immediately report the suspicion and information to the Director, followed by completion of a Critical Incident System (CIS) report including the results of an investigation and actions taken in response to the incident by identified timelines.

Further, Inspector #625 reviewed the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", last updated April 2017, which identified that staff were to refer to the "Abuse and Neglect Decision Tree - Appendix 1", last updated April 2017, which indicated that staff were to proceed to the appropriate Ontario LTC decision tree and submit a CIS report, which included Appendix 8 - Ontario LTC Financial Abuse Decision Tree.

During resident interviews, residents #013 and #014 stated to Inspectors #625 and #577, respectively, that they had missing money.

During an interview with the Registered Social Worker (RSW) regarding resident finances in the home, they stated that residents #030 and #031 had been financially abused while residing in the home.

Inspector #625 reviewed the progress notes for resident #030 which included notes from specific dates in July and September 2017, which referred to suspicions and beliefs that the resident was being financially abused, as well as actions the home implemented to limit further financial abuse.

Inspector #625 also reviewed progress notes for resident #031 which included notes from specific dates in December 2016, March 2017, and September 2018,

which referred to suspicions and beliefs that the resident was being financially abused, as well as actions the home implemented to limit further financial abuse.

Inspector #625 searched intakes associated with Critical Incident System (CIS) reports submitted from the home for dates between January 2016, and September 2018, and was unable to locate a corresponding intake for resident #030 or resident #031, where the Director had been notified of suspected financial abuse of either resident, including information to support the suspicion, investigation details, actions taken by the home, or the results of the investigation.

During a second interview with the RSW, they acknowledged to Inspector #625 that there had been a reasonable suspicion that financial abuse had occurred towards residents #030 and #031 but that neither suspicion had been reported to the Director, although both allegations had been discussed during the home's leadership meetings. The RSW stated they had never been informed that the Director would have to be notified of the abuse. Further, the RSW acknowledged that the financial abuse should have been reported to the Director and that they would have reported it had they known it was required. Lastly, the RSW reviewed the "Ontario LTC Financial Abuse Decision Tree" with the Inspector and acknowledged that the home's policies related to abuse had not been followed.

During an interview with the ED, they stated to Inspector #625 that financial abuse involving residents #030 and #031 had occurred and that suspicions of abuse of both residents should have been reported to the Director. The ED was not able to locate a CIS report for either resident related to the suspicion of financial abuse. The ED stated that the home's abuse policies had not been followed. [s. 20. (1)]

2. A complaint was received by the Director on a day in July 2018, alleging staff to resident neglect of residents' #024, #025 and #026.

During an interview with the staff member #113, they identified to Inspector #621 that they had suspicions of neglect of residents' #024, #025 and #026 by staff member #114 and decided to make a report to the Ministry of Health and Long-Term Care (MOHLTC) about their concerns. When the Inspector asked about the home's policy for mandatory reporting of suspected abuse or neglect, staff member #113 identified that consistent with the home's policy, staff were to immediately report their suspicions to their reporting manager/designate, who would then follow up with the Administrator and/or DOC. When the Inspector inquired with staff member #113 if they had immediately reported their suspicions

of neglect of the three residents to their reporting manager/designate utilizing the home's policy for mandatory reporting, they identified that they had not.

Inspector #621 reviewed a copy of the home's policy entitled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting – RC-02-01-02", last updated April 2017, which identified that anyone who witnessed or suspected abuse or neglect of a resident by another resident, staff or other person must report the incident immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior supervisor on shift at that time. Additionally, the policy identified that the person reporting the suspected abuse would follow the home's reporting process and provincial requirements to ensure the information was provided to the home Administrator/designate immediately.

During an interview with the DOC, they reported to Inspector #621 that if a staff member witnessed, or knew of alleged or suspected abuse or neglect of a resident, it was expected that the staff member would follow the home's mandatory reporting policy and immediately notify the RN on duty; who would then immediately make a report to the DOC and/or Administrator, and follow the home's policy to contact the Ministry of Health and Long-Term Care (MOHLTC). The DOC stated that if it was after-hours, the RN on duty would immediately make the report to the Manager on-call, who would then notify the DOC and/or Administrator, and contact the MOHLTC after-hours pager. The DOC confirmed with Inspector #621 that the home had not received a report from anyone, including home's staff with regards to suspected neglect of resident #024, #025 or #026. [s. 20. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 004

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

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

During the inspection, resident #001 was observed by Inspector #625 to be wearing shoes with no socks.

Inspector #625 reviewed resident #001's current care plan, which identified that the resident had impaired skin integrity and that staff were to monitor and treat the altered skin integrity as per the Treatment Administrator Records (TARs). An entry on the TAR related to the altered skin integrity had been initiated on a specific day in July 2018.

The Inspector further reviewed resident #001's August 2018 TAR which identified treatments to the resident's altered skin integrity had been discontinued on a specific day in August 2018, and remained discontinued for the duration of the month. The Inspector also reviewed the resident's September 2018 TAR, which listed a treatment to the resident's altered skin integrity that was applied on a specific number of days in September 2018, and then discontinued on a later date in September 2018.

During an interview with RPN #119, they confirmed to Inspector #625 that resident #001's August 2018 TAR identified that the treatment to their altered skin integrity discontinued on a particular day in August 2018. The RPN also stated that they had deleted an entry related to the resident's altered skin integrity from the September 2018 TAR, and that it was only active on two particular days in September 2018. The RPN further acknowledged that it was not clear what staff were to do for the resident's altered skin integrity as the intervention listed in the care plan, which referred to their TAR, should have been removed from the care plan.

During an interview with the DOC, they acknowledged that resident #001's plan of care did not provide clear direction to staff if the resident's care plan listed a skin integrity issue, which referred staff to the TAR for directions, and then the TAR did not include a treatment or dressing for the impaired skin integrity. [s.6(1)(c)]

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

A complaint was received by the Director alleging that resident #027's responsive behaviours were not being adequately managed by the home.

During the inspection, Inspector #621 observed resident #027 seated in a particular area of the resident home area, and engaged in a specific activity.

During an interview with PSWs #109 and #112, they reported to Inspector #621 that resident #027 had responsive behaviours and some of the most effective strategies helping keep the resident calm and happy throughout the day was to ensure that the resident could engaged in a certain activity. PSWs #109 and #112 indicated that resident #027 would in fact, initiate engagement in the said activity on their own. When the Inspector asked where staff could find information pertaining to a resident's care needs and preferences, PSWs #109 and #112 identified that this information could be found on the resident's care plan.

During a review of resident' #027's health record, including a specific section of resident #017's most current care plan, Inspector #621 found no information identifying that staff were to ensure resident #027 had access to particular items to perform a specific activity as part of this resident's responsive behavior care planning interventions.

During an interview with the DOC, they reported to Inspector #621 that resident #027 had responsive behaviours, and some of the successful strategies used by home's staff, (which the resident gravitated to on their own), included engagement of the resident in a specific activity, using particular items, in a certain area of the home.

On review of resident #027's most current care plan, including interventions listed in the a specific section of the care plan, the DOC confirmed to Inspector #621 that the care plan was not based on the assessment of this residents needs and preferences, as it did not identify as part of their care plan interventions, the use of particular items during a specific activity, in a certain area of the home, as a preferred activity for this resident, and should have. [s.6(2)]

3. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

Inspector #577 had observed that resident #009 did not have a specific care activity completed for them on a specific day in September 2018. Subsequent observations by Inspector #625 identified that resident #009 continued to not have a specific care activity completed for them on two subsequent days in September 2018.
Inspector #625 reviewed the home's policy titled "Daily Personal Care and Grooming - RC-06-01-01", last updated April 2017, which identified that care staff were to document the care provided to residents on a daily care record.

The Inspector reviewed resident #009's health care record, which included their Point of Care (POC) tasks that included a reference to a particular care activity. The Inspector however, was unable to locate an individualized task which identified when the resident had the particular care activity completed.

During interview with PSW #120, they stated to Inspector #625 that PSWs no longer documented when residents had a specific care activity completed for them, once POC was initiated for documentation of care in the home.

During an interview with PSW #121, they stated to Inspector #625 that when PSWs began documenting electronically [on POC], that a particular resident care activity was no longer documented. PSW #121 however, identified that prior to changing over to the POC, the particular care activity in question, had been documented using a paper documentation method.

During an interview with PSW #122, they stated to Inspector #625 that a particular care activity was to be completed by staff when they completed morning care for residents, but the category on POC did not allow staff to document and distinguish the specific care activity separate from the general categories listed. The PSW acknowledged that the list generated on POC did not reflect the actual individualized care that was provided to residents.

During an interview with Resident Assessment Instrument (RAI) Coordinator, they stated that POC did not contain an individualized task for PSWs to document a particular activity that had occurred and, as a result, the documentation of that care activity had not been completed for any residents on POC. The RAI Coordinator also stated that staff should have documented that specific care activity was provided, but the categories that they had been documenting on were too broad.

During an interview with the ED, they stated that the home had begun documenting using POC in June or July of 2018; that PSWs should have been documenting when residents had a particular care activity completed; and that the care activity should have been listed as an individualized task where appropriate, for certain residents. [s.6(9)1]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months, and at any other

time when the care set out in the plan had not been effective.

On a specific day in September 2018, resident #003 was observed in their mobility aide, with a safety device applied, which served as a potential restraint.

A review of resident #003's care plan indicated that the safety device was to be applied when the resident was in their mobility aide.

A review of the physician orders dated from December 2017, identified an order for a specific type of safety device to be applied when the resident was in their mobility aide, and included a signed consent from the substitute decision maker (SDM).

During frequent observations of resident #003 on specific days in September 2018, Inspector #577 observed the resident's safety device unsecured.

During an interview with PT #124, they reported to Inspector #577 that resident #003's safety device posed a safety risk when the resident was seated in their mobility aide and became agitated.

During an interview with RPN #125, they reported to Inspector #577 that staff did not secure resident #003's safety device when they were in their mobility aide, due to the resident becoming agitated when it was applied, as well as the resident being able to remove the safety device on their own. RPN #125 also reported that the resident had a history of sliding out of their mobility aide and onto the floor.

A review of the home's policy titled "Care Planning – RC-05-01-01", revised April 2017, indicated that staff were to ensure that the care plan was revised to reflect the resident's current needs; staff were required to review, evaluate and revise the effectiveness of the interventions outlined on the care plan on a quarterly basis, following admission, and whenever there was a change in the resident's condition.

During an interview with the DOC, they reported to Inspector #577 that the safety device was considered a Personal Assistive Safety Device (PASD) for resident #003; that the order for the safety device needed to be reassessed for the resident's safety, as the resident was known to slide underneath the safety device, when it was applied. The DOC also identified that staff should have communicated to the physician the safety concerns they had with regards to the

use of a safety device with this resident, and that resident #003's plan of care had not been revised to reflect the changes in this resident's care needs, with respect to the use of a safety device.

During an interview with the ED, they confirmed with Inspector #577 that staff should have had the order for resident #003's safety device discontinued. [s.6(10)(b)]

5. A complaint was received by the Director on a day in April 2018, which alleged that resident #007 had frequent falls, and that interventions had not been implemented for the resident.

A review of resident #007's care plan indicated that as part of falls prevention, the resident had interventions including a specific number of safety devices. During a review of the resident's progress notes, Inspector #577 found that the identified safety devices had been initiated on particular day in April 2018.

During the inspection, Inspector #577 observed resident #007 sitting in their mobility aide in their room, and on further observation identified that neither of the identified safety devices were present.

During an interview with PSW's #109 and PSW #112, they both reported to Inspector #577 that according to the care plan, resident #007 required the use of a specific number and type of safety devices. However, PSWs #109 and #112 indicated that the resident and one of their family members had been found consistently removing the safety devices, and as a consequence, staff were not applying/re-applying the safety devices with this resident.

During an interview with RPN #119, they confirmed with the Inspector that the care plan for resident #007 indicated the use a specific number and type of safety devices, and that the resident had been found removing the safety devices. Together, Inspector #577 and RPN #119 inspected resident #007's room, and located one of the safety devices in a bedside drawer. RPN #119 reported to the Inspector that resident #007 should have been reassessed, and the care plan revised, as the use of safety devices had been found ineffective.

During an interview with the DOC, they reported to Inspector #577 that resident #007's plan of care had not been revised to reflect the changes that occurred with respect to the use of specified safety devices, and should have been. [s.6(10)(b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident; and to to ensure that the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On three consecutive days in September 2018, Inspector #577 observed the toilet located in the shared washroom of a particular resident room, to be soiled. During further observation on the third day, Inspector #196 also observed the floor at the entrance of the washroom, an area on the wall adjacent to the doorway of the

washroom and the inner aspect of the toilet seat in the washroom of room #205 to be soiled. Additionally, there was a strong odour present within the washroom; in the shared resident room area; and within the corridor of the resident home area.

During an interview with PSW #135, they reported to Inspector #196 that in the identified resident room, a specified number of residents toileted themselves, while a specific resident required the assistance of a particular number of staff with continence care. Together with the Inspector, PSW #135 observed the shared washroom in the resident room and observed the grab bar, the sink counter top, the edge of the washroom wall, and the floor by the door to be soiled.

On September 18, 2018, Inspector #196 observed the washroom in specific resident room, and noted that same amount and type of soiling had remained unchanged on the wall adjacent to the doorway.

On September 19, 2018, Inspector #196 observed the washroom in the same resident room to again have a soiled toilet seat.

During an interview with Housekeeping Aide #136, they reported to the Inspector that the resident room in question, was the one room on the unit that usually had issues which required additional cleaning.

During an interview with Housekeeping Aide #137, they reported to the Inspector that as part of their housekeeping duties, they were responsible to clean their assigned unit and resident rooms areas. They identified that if a resident was in the room, they would leave and return later in the day to complete cleaning of that room. In addition, they stated that if a resident room needed cleaning more than once a day, the nurse would come and inform them of the issue, and they would follow up with the required cleaning at that time. Housekeeping Aide #137 indicated that they were not aware of any resident rooms on the specified unit which required cleaning more than once a day.

Inspector #196 and the Executive Director (ED), together observed the washroom in the specific resident room on a day in September 2018. The ED observed the soiling and debris located on the washroom wall and confirmed to the Inspector that the wall was soiled, and should have been cleaned.

During an interview with the Environmental Services Manager (ESM), they reported to Inspector #196 that the housekeeping aides had time to clean each

resident room and washroom once daily, but that they did not have time to go back later in their shift to check the washrooms or resident rooms again. Further, the ESM stated that they may have to make a plan to do this for resident rooms and washrooms that require the extra cleaning, and identified to the Inspector that they were attempting to hire an additional housekeeping aide to work on the evening shifts. [s.15(2)(a)]

2. On a day in September 2018, Inspector #625 observed resident #038 seated in their wheelchair, which was unclean with food debris on the safety device, seat surface, straps at the side, and on the back of the chair.

During further observations conducted by Inspector #196, they identified resident #038's wheelchair was unclean with food debris on the safety device, seat surface and on the chair frame.

On a subsequent day in September 2018, and together with the Inspector, RPN #100, observed resident #038's wheelchair and confirmed to the Inspector that it was soiled with food debris. RPN #100 added that the wheelchair was to be cleaned weekly and anytime when the mobility aide was observed to be soiled.

During an interview with PSW #138, they reported to the Inspector that the night shift PSWs were assigned to complete the cleaning of wheelchairs, and that they would also clean a wheelchair if they saw it was dirty.

During an interview with PSW #139 on a day in September 2018, they reported to Inspector #196 that according to the "resident care and bath list", it identified that resident #038 was to have their wheelchair cleaned on the a specified shift, once each week. Together the Inspector and PSW #139 observed the resident's wheelchair, and the PSW confirmed that the chair was unclean on the seat surface, safety device straps, and on the posterior area of the chair.

Inspector #196 reviewed the "Resident Care Equipment - policy RC-07-01-01", last updated April 2017, as provided by the DOC. The policy read "All resident care equipment and personal care items will be cleaned/sanitized prior to and between resident use, and will be used and serviced/calibrated in compliance with all manufacturer's instructions, guidelines and recommendations."

During observations with the ED, they confirmed to Inspector #196 that resident #038's wheelchair was soiled, and that it should have been cleaned as listed on

the "resident care and bath sheet", and that this had not been done. [s.15(2)(a)]

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

On a specific day in September 2018, Inspector #625 observed a loose grab bar with one screw elevated from the screw hole in a resident's washroom.

Together with Inspector #196, the Environmental Services Manager (ESM) observed the loose grab bar and confirmed it was a safety concern for residents. The ESM then proceeded to use a screw driver to affix the grab bar.

During an interview with the ESM, they reported to Inspector #196 that staff were to complete a requisition form to have the maintenance staff address any maintenance issues and this had not been done. [s.15(2)(c)]

4. On a specific day in September 2018, Inspector #621 observed a towel bar in a resident washroom, which was detached from the wall on its left side, and hanging at a diagonal. The Inspector noted staff still attempting to place towels and face cloths on the towel bar.

On the same day in September 2018, Inspector #625 observed the washroom sink, to have one centimeter (cm) x one and one-half cm hole in the enamel. On a subsequent day in September 2018, Inspector #621 observed the same hole in the basin of the sink, which appeared to have been previously filled with an epoxy resin. This same epoxy resin had spilled onto another area of the sink basin and hardened into 2 cm by 3 cm patch, resulting in an uneven surface.

During the inspection, Inspector #196 observed a damaged ceiling tile in a washroom.

During an interview with RPN #100, they reported to Inspector #621 that when there were identified maintenance issues on the resident home areas, that staff were to complete a requisition form, which was kept on the unit in the back room of the nursing station, and that maintenance staff would check these requisition forms daily in order to address any concerns. Together with the Inspector, the RPN reviewed all requisition work order requests made for 2018 and found no requisitions from staff for issues in resident washrooms.

Together with Inspector #621, the Environmental Services Manager (ESM):
a) observed the loose towel bar, and confirmed that this washroom fixture was not maintained properly, and needed repair;
b) observed the attempted patch of the damaged sink, and confirmed that the sink was not in good repair and the attempted fix could pose an infection control issue; and
c) the ceiling tile located in a washroom had staining from previous water damage and needed replacement.

During an interview with the ESM, they reported to Inspector #621 that staff were to complete a requisition form, which maintenance staff checked daily to address any maintenance issues. The ESM identified that home's staff were not consistently following the home's written reporting process for maintenance concerns and that requisitions for the issues identified in each of the washrooms found had not been done. [s.15(2)(c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment is kept clean and sanitary; and to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 has failed to ensure that a person who had reasonable grounds to suspect misuse or misappropriation of a resident's money had occurred, or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Ontario Regulation 79/10, s. 2 (1) defines financial abuse as any misappropriation or misuse of a resident's money or property.

During resident interviews, residents #013 and #014 stated to Inspectors #625 and #577, respectively, that they had missing money.

During an interview with Inspector #625, the ED stated that there were some residents in the home who were found to be regularly giving their money away to family members. As a consequence, the home's Registered Social Worker (RSW) was working with the local police to establish a committee to review those residents affected.

During an interview with the RSW, they reported to Inspector #625 that residents #030 and #031 had been financially abused while residing in the home.

Inspector #625 reviewed the home's policy titled "Jurisdictional Reporting Requirements - Appendix 2", last updated April 2017, which identified that mandatory reporting under the LTCHA section 24(1) required a person to make an immediate report to the Director where there was a reasonable suspicion that misuse or misappropriation of a resident's money had occurred, or may occur. The policy also identified that the results of the investigation into the abuse, and any actions taken in response to the incident, must be submitted by management within 10 days or earlier if requested, using the CIS.

The Inspector also reviewed the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", last updated April 2017, which identified that staff were to refer to the "Extendicare Abuse and Neglect Decision Tree - Appendix 1" last updated April 2017, which identified that staff were to proceed to the appropriate Ontario LTC decision tree and submit a CIS report, which included Appendix 8 - Ontario LTC Financial Abuse Decision Tree.

A review of the "Ontario LTC Financial Abuse Decision Tree - Appendix 8", last updated April 2017, identified that, if a licensee became aware of alleged, suspected or witnessed financial abuse of a resident, and there were reasonable grounds to suspect that financial abuse had occurred or may occur, the licensee was required to immediately report the suspicion and information to Director and send a report including the results of the investigation and actions taken in response to incident via CIS within 10 days or earlier if requested by Director.

Inspector #625 reviewed the progress notes for resident #030 which included notes dated from specific dates in July and September 2017, which referred to suspicions and beliefs that the resident was being financially abused, as well as actions the home implemented to limit further financial abuse. The Inspector also reviewed progress notes for resident #031 which included notes dated from December 2016, March 2017, and September 2018, which referred to suspicions and beliefs that the resident was being financially abused, as well as actions the home implemented to limit further financial abuse.

During a second interview with the RSW, they acknowledged that there had been a reasonable suspicion that financial abuse had occurred towards residents #030 and #031, but that neither suspicion had been reported to the Director, although both allegations had been discussed during the home's morning leadership meetings. The RSW stated they had never been informed that the Director would have to be notified of the abuse. Additionally, the RSW acknowledged that the

financial abuse should have been reported to the Director, and that they would have reported it had they known it was required.

During an interview with the ED, they stated that financial abuse involving residents #030 and #031 had occurred, and that both suspicions should have been reported to the Director. The ED was not able to locate a CIS report for either resident related to the suspicion of financial abuse. [s. 24. (1) 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 to ensure that a person who has reasonable grounds to suspect that misuse or misappropriation of a resident's money has occurred, or may occur, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following was complied with in respect to each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: Where, under the program, staff use of any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices, assistive aids or positioning aids were appropriate for the resident based on the resident's condition.

On three consecutive days in September 2018, resident #003 was observed to be sliding forward in their wheelchair, with their buttocks positioned near the edge of their seat.

On a day in September 2018, resident #001 was observed in a wheelchair that was an inappropriate height and width for the resident.

During a review of the progress notes for resident #003, Inspector #577 identified the following documentation:
1) On a specific day in January 2018, the resident slid off their wheelchair onto the floor;
2) On a specific day in February 2018, the resident had been observed falling off their wheelchair;
3) On a specific day in March 2018, the resident to be sliding in their wheelchair;
4) On a specific day in May 2018, the resident found sliding down in their wheelchair until they had slid almost into a reclining position;
5) On another specific day in May 13, 2018, the resident found to be pushing themselves off the wheelchair several times;
6) On a specific day in June 2018, the resident slid off their wheelchair a specified number of times during a specific time period;
7) On another specific day in June 2018, the resident was found lying on the floor with their wheel chair beside them;
8) On another day in June 2018, the resident slid from their wheelchair onto the floor;
9) On a further day in June 2018, the resident had been provided with a tilt wheelchair with a seatbelt;
10) On a day in July 2018, the resident made attempts to slide out of their wheelchair; had tried to turn their wheelchair and fell onto the floor;
11) On another day in July 2018, a referral had been sent to CCAC Occupational therapist;
12) On a specific day in August 2018, the resident had made attempts to throw them self out of their wheelchair;
13) On another specific day in August, 2018, the Occupational therapist from CCAC had done measurements for wheelchair;
14) On four additional days in August 2018, the resident made attempts to slide out of their chair; and
15) On three days in September 2018, the resident had made attempts to slide out of their wheelchair.

During a review of the progress notes for resident #001, Inspector #577 identified the following notations:
1) On a day in May 2018, the resident was found sliding off sideways from their wheelchair;
2) On a day in August 2018, the resident had slid out of their wheelchair; and
3) On another day in August 2018, the resident had fallen to the floor out of their

wheelchair.

During an interview with PT #124, they reported to Inspector #577 that resident #003 was not seated in a proper wheelchair. They also identified that there was an issue with resident #001's wheelchair being an inappropriate height and width for the resident. PT #124 indicated that the home did not have an occupational therapist (OT) that could complete the seating assessment and application to the Assistive Devices Program (ADP), and that they did not have ADP authority, which had created an issue for getting residents assessed and fitted with proper wheelchairs. PT #124 identified that they had not initiated any OT referrals.

During an interview with Program Manager #107, they reported to Inspector #577 that residents who had required wheelchairs, would be given a wheelchair from the home's existing supplies, and together, they and the PT would decide on the proper fit of a wheelchair for each resident They further reported that the home had no one designated to complete preventative maintenance of the home's wheelchairs and there had been times when residents who were admitted to hospital, would return to the home with a wheelchair that was "on loan". Lastly, Program Manager #107 confirmed that the home's wheelchair vendor #145 had discontinued the supply and preventative maintenance of wheelchairs for the home two years prior, and the home had been unable to source an alternative vendor since.

During an interview with the ED, they reported to Inspector #577 that PT #127 had been previously employed in the home until December 2017, and that they had the required ADP approval up until that time. The ED identified that as a result of PT #127 leaving their employment with the home, the home was unable to access ADP services from December 2017 until July 26, 2018, when the home secured the services of an OT from the Northwest Local Health Integration Network (NWLHIN), for resident #003, and for other resident's on a referral basis.

During an interview with the NWLHIN OT, they confirmed with Inspector #577 that they had not been involved with referrals for ADP with this home, or any long-term care homes in the region prior to July 26, 2018, as the NWLHIN was previously not accepting OT referrals. The NWLHIN OT reported to the Inspector that they received a referral from the home for resident #003, and followed up with an ADP application for this resident, which was completed on a specific date in August 2018, and submitted to vendor #144 for processing. [s. 30. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following is complied with in respect to each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: Where, under the program, staff use of any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices, assistive aids or positioning aids are appropriate for the resident based on the resident's condition, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received individualized personal care, including hygiene care and grooming, on a daily basis.

On a day in September 2018, Inspector #577 observed that a particular care activity that was required, had been not completed for resident #009. During subsequent observations in September 2018, Inspector #625, again observed that a particular care activity that resident #009 required, had not been completed. Inspector #625 reviewed resident #009's current care plan which identified that staff were to complete a certain care activity with the resident when required.

A review of the home's policy titled "Daily Personal Care and Grooming – RC-06-

01-01", last updated April 2017, identified that staff were to provide individualized care as documented on the care plan, assist residents who required grooming, with their personal care products, and that "A.M. Personal Care" involved morning care that was provided when the resident awoke for the day.

During an interview with PSW #118 on a particular day in September 2018, they stated to Inspector #625 that resident #009 required staff to complete a certain care activity with them and that PSW #128 had completed the resident's care on that day shift.

During an interview with PSW #128 on the same day, they stated to Inspector #625 that they had not completed a specific care activity with resident #009 as they were running behind.

During interviews with PSWs #120 and #121, they stated that resident #009 was scheduled to be bathed on two specific days of the week, and that staff were supposed to complete the specified care activity for the resident when they bathed them. PSW #120 also stated that, if residents got up in the morning and needed to have the specified care activity completed then, they should complete that care activity at that time. PSW #120 reviewed Point of Care (POC) documentation, which indicated the resident had been bathed on a specific day in September 2018.

Inspector #625 reviewed the floor's current "Resident Care and Bath List", dated August 2018, which identified that resident #009 was to be bathed on two particular days each week.

During an interview with RPN #106, they stated that resident #009 was supposed to have a certain care activity completed on their bath days and, if their bath days were on specific days, that was when staff were required to completed the care activity with the resident.

During an interview with Inspector #625, the DOC acknowledged that residents should have a certain care activity completed with them as needed; as outlined in their care plans; and in accordance with the home's policy. The DOC also acknowledged that, if resident #009 had been observed to require the completion of the specified care activity by the Inspectors on three consecutive days, the resident had not have the care activity completed with them as required. [s.32]

2. On a day in September 2018, resident #001 was observed by Inspector #577 to be un-groomed. During subsequent observations by Inspector #625, on two other day in September 2018, resident #001 was again observed to be un-groomed.

A review of resident #001's care plan identified that the resident required extensive assistance from staff to complete a particular care activity.

Inspector #625 reviewed the home's policy titled "Daily Personal Care and Grooming - RC-06-01-01", last updated April 2017, which identified that staff would provide individualized resident care as documented in their care plan, and were to provide morning care when the resident awakened for the day, which usually included hair care.

During an interview with PSW #129, they stated to Inspector #625 that, although the resident was assigned to the PSW on that day shift, they had not completed morning care for the resident, as someone on the night shift had gotten the resident up early and dressed them.

During an interview with RPN # 119, they stated to Inspector #625 that resident #001's was observed to be ungroomed, and that it looked like the resident had just rolled out of bed. The RPN further stated that they knew the resident had not just rolled out of bed, and that their appearance looked like it did as they had not had a particular care activity completed for them.

During an interview with Inspector #625, the DOC acknowledged that resident #001 required assistance from staff for a particular care activity, as per their care plan and home's policy, to ensure they were properly groomed. [s.32]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following interdisciplinary programs were developed and implemented in the home: 4. A pain management program to identify pain in residents and manage pain.

On review of the Long-Term Care Homes (LTCH) Licensee Confirmation Checklist for Quality Improvement and Required Programs, provided to the ED for completion, Inspector #621 identified that the response section to the question which asked if the licensee had ensured that a pain management program was developed and implemented in the home, was left blank.

During an interview with the DOC, they reported to Inspector #621 that the home had begun working with their Registered Nurses' Association of Ontario (RNAO) North West Long-Term Care team contact in April 2018, to help get required programs, including a pain management program, up and running in the home. However, the DOC identified that that the home had not been able to develop and implement a pain management program by the time of inspection, to identify and manage pain within the resident population.

During an interview with the ED, they confirmed to Inspector #621 that the home did not have an interdisciplinary pain management program developed and implemented. [s. 48. (1) 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 to ensure that the following interdisciplinary programs are developed and implemented in the home: 4. A pain management program to identify pain in residents and manage pain, to be implemented voluntarily.

WN #11: 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.

Resident #004 was identified as having altered skin integrity.

A review of resident #004's progress notes dated from July 2018, indicated that the resident had developed altered skin integrity; treatment cream was initiated on a specific date in July 2018, for a particular time frame; and a progress note dated on a later date in July 2018, indicated that there was a change in the status of the altered skin integrity.

A review of resident #004's wound assessments from a specific date in July 2018, indicated completion of a "Weekly Impaired Skin Integrity Assessment", which documented altered skin integrity of a specific severity. On further review of resident #004's health record, Inspector #577 found no further wound assessment documentation.

A review of the home's policy titled "Skin and Wound Management - RC-23-01-01", revised February 2017, it identified that staff were required to initiate a “Bates Jensen Wound Assessment Tool” for pressure ulcers and complete at a minimum, every seven days. Further, the policy identified that a “Weekly Impaired Skin Integrity Assessment” was required weekly for all other skin integrity issues that were not pressure ulcers.

During an interview with RN #110, they reported to Inspector #577 that resident #004’s skin integrity had improved, and confirmed that the only skin assessment that had been completed by staff for changes in this resident’s skin integrity was dated from a specific day in July 2018.

During an interview with RN #131, they reported to Inspector #577 that, when resident #004’s skin breakdown was identified in July 2018, a weekly skin assessment had been completed, RN #131 however, identified that after the initial assessment, no further skin and wound assessment documentation had been completed for this resident.

During an interview with the DOC, they reported to Inspector #577 that the “Bates Jensen Wound Assessment Tool” was required to be completed by staff initially upon discovery of a wound, and weekly thereafter; as well as a “Weekly Impaired Skin Integrity Assessment” completed every seven days, for all other skin integrity issues. Together the Inspector and DOC reviewed resident #004’s health records, and the DOC confirmed that staff had documented a “Weekly Impaired Skin Integrity Assessment” on a specific date in July 2018, but had not completed a “Bates Jensen Wound Assessment Tool” for the altered skin integrity, nor had they completed any subsequent wound or skin assessments thereafter. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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 #12: The Licensee has failed to comply with O.Reg 79/10, s. 59. Therapy services
Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include,
(a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs; and
(b) occupational therapy and speech-language therapy. O. Reg. 79/10, s. 59.

Findings/Faits saillants :

1. The licensee has failed to ensure that therapy services for residents of the home were arranged or provided under section 9 of the Act that included occupational therapy.

During observations of resident #003 on a specified number of day in September 2018, they were observed to have been sliding forward in their wheelchair, with their buttocks positioned near the edge of the seat.

During observations of resident #001 on a day in September 2018, their wheelchair was observed to be of an inappropriate height and width for the resident.

During an interview with PT #124, they reported to Inspector #577 that resident #003 was not seated in a proper wheelchair. They further reported that the home did not have occupational therapy that could have provided Assistive Devices Program (ADP) service for seating assessments. Additionally, PT #124 reported that they did not have ADP authority which had created an issue for the residents that needed to be fitted with proper wheelchairs.

During an interview with PT #124, they reported that resident #001's wheelchair was an inappropriate height and width for the resident. PT #124 further reported that an ADP referral had not been processed for this resident as the home did not have an OT, and PT #124 did not have ADP authorization.

During an interview with the ED, they reported that the home had never had occupational therapy services. They further reported that as of July 26, 2018, the North West Local Health Integration Network (NWLHIN) Home and Community Care had begun to accept occupational therapy referrals, on a case by case basis for the home's residents. [s. 59. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include occupational therapy, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager

Specifically failed to comply with the following:

s. 75. (3) The licensee shall ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. O. Reg. 79/10, s. 75 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a nutrition manager was on site at the home and working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities.

O. Reg., 79/10, s.75(4)(b) identifies that for the purposes of subsection (3) the minimum number of hours per week shall be calculated based on the number of residents residing in the home for the week, including absent residents, if the occupancy of the home is less than 97 per cent.

During a review of minutes from the August 2018, Professional Advisory meeting, Inspector #196 identified a section of the minutes where the home's Registered Dietitian reported that due to issues of recruitment for cooking staff, the Nutrition Manager had been working in the capacity of a cook, in addition to her role as the home's Nutrition Manager.

During an interview with the Nutrition Manager (NM), they confirmed with Inspector #621 that due to loss of cooking staff in their department, and an inability to recruit staff with the required qualifications, that they had been filling in as Cook #2 since May 12, 2018. The NM identified that as result of working in the

kitchen, they had only been able to provide between 7.5 and 15 hours (hrs) weekly to fulfill duties of the NM since that time. The NM confirmed to the Inspector that they were hired to serve in the capacity of the on-site NM to provide 37.5 hrs weekly, and that this did not include the function of working as one of the cooking staff in the home.

The NM provided copies of the dietary staff schedule to Inspector #621 for eight weeks between July 21 and September 14, 2018, and confirmed that they had worked on a weekly basis the following hours as the NM in the home:
10.5 hrs for week of July 21 – 27, 2018;
18 hrs for week of July 28 – August 3, 2018;
10.5 hrs for the weeks of August 4 – 10, 11 – 17, 18 – 24, and 25 – 31, 2018; and
10.5 hrs for the weeks of September 1 – 7, and 8 – 14, 2018.

Inspector #621 reviewed the home's resident census report as provided by Office Manager #134, between July 21 and September 14, 2018, which identified the average weekly resident census (including absent residents), to be between 80 and 84 residents out of a total bed census for the home of 96. This resulted in a total occupancy rate of 83 to 88 per cent for the same time period.

The calculation as identified in O. Reg. 70/10, s.75(4), for the required NM hours, were identified as between 25.6 to 26.9 hrs a week.

During a subsequent interview with the NM, they confirmed that for the period of July 21 to September 14, 2018, they had provided less than the required minimum number of hours a week to be on-site at the home, in the capacity of the Nutrition Manager. [s. 75. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a nutrition manager is on site at the home and working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure, that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that procedures were developed and implemented for addressing incidents of lingering offensive odours.

A complaint was received by the Director identifying urine odours on the third floor unit of the home.

Observations were made of a specific resident room over several dates, at different times, during the inspection, and urine odours were evident and lingering.

The ESM provided an "Odour Control Investigation Tool", last updated December 2016, and an attached policy. The tool and policy were reviewed by Inspector #196, and indicated that "All reports of lingering odour will be investigated" and referred to the use of the tool and staff were to "immediately report any lingering odour to the Support Services Manager/designate". The ESM confirmed to the Inspector that this tool had not yet been in use at the home.

During an interview with the ESM, they reported to Inspector #196 that the home had deodorizers placed in the corridors of both units and the housekeeping staff had enzymatic cleaners to clean resident washrooms. In addition, they reported that at this time, the housekeeping aides only had time to clean each resident room and washroom once daily and they needed to make a plan for those rooms and washrooms that required extra cleaning.

Together with the Inspector, the ESM and Housekeeping Aide #140, observed and confirmed the urine odours within the identified resident room. In addition, Housekeeping Aide #140, showed a specific area of flooring in the resident room where repeated urine spills had contributed to the persistent odours, and that corners on the flooring had lifted, with the urine odour remaining despite efforts of housekeeping staff to clean the area with enzyme cleaner. [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that procedures are developed and implemented for, cleaning of the home, including, resident bedrooms, floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, to be implemented voluntarily.

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 the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct were given an opportunity to participate fully in the care conferences.

During an interview with Inspector #196, resident #011's family member #103 stated that they could not remember being invited to a care conference for the resident since the resident's admission, or since they had become the substitute decision-maker (SDM) for the resident.

Inspector #625 reviewed resident #011's progress notes which identified that an admission care conference was held for the resident in 2013, and the resident's annual care conferences had occurred annual thereafter. The documentation related to the care conferences indicated that the resident's family (which included the resident's SDM) was not present and did not participate in any of the conferences. The Inspector was not able to locate documentation that the SDM had been notified of the care conferences.

Inspector #625 also reviewed the electronic medical record (e-MAR) which identified completion of Interdisciplinary Team Care Conference assessment reports for each of the annual care conferences from 2014 to 2017. The Inspector noted that the reports identified that the SDM was not in attendance at any of the care conferences.

During an interview with the Registered Social Worker (RSW), they stated that they notified residents' families of care conferences by letter or by phone, and that they documented the family contact by phone in the progress notes. The RSW was unable to locate documentation to confirm that they had notified resident #011's SDM of their 2017 care conference and stated to the Inspector that they had not maintained any documentation of notifications for the 2016 care conferences in the home. The RSW also identified that they could not recall notifying resident #011's SDM in 2016 or 2017, but that they should have been invited to participate.

During an interview with the DOC, they stated that they could not confirm that resident #011's SDM had been invited to participate in their 2017 annual care conference. The DOC was unable to locate documentation in the residents' health care record, or in the home's interdisciplinary communications, which identified if the resident's SDM had been notified of the conference. The DOC acknowledged that the resident's SDM should have been invited to participate in their annual and admission care conferences. [s. 27. (1)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was assisted with getting dressed as required, and was dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear.

On a specific day in September 2018, resident #001 was observed by Inspector #625 to be wearing clothing and shoes that were soiled, and wearing shoes with no socks on. On three additional dates in September 2018, the resident was again observed by Inspector #625 to be dressed in soiled clothing, and to be wearing shoes with no socks on.

A review of the home's policy titled "Daily Personal Care and Grooming – RC-06-01-01", last updated April 2017, identified that staff were to ensure each resident was appropriately dressed, suitable for the season and time of day.

Inspector #625 reviewed resident #001's current care plan which identified that staff were to provide a certain level of assistance to the resident with personal care.

During an interview with PSW #135, they confirmed that resident #001 was wearing soiled clothing and shoes, and that the resident was wearing shoes on without socks. The PSW further stated that the resident should be dressed in clean clothing and should have socks on when wearing shoes.

During an interview with RPN #119, they stated that staff were responsible to ensure that resident #001 was dressed, and wearing clean clothing. The RPN stated that the resident required staff to assist them to dress. The RPN further confirmed to Inspector #625 that the resident's clothing was soiled and the resident should have been changed into clean clothing.

During an interview with the DOC, they acknowledged that resident #001 should have been wearing socks with their shoes and should have been provided with assistance from staff with dressing, so that they were wearing clean clothing (including their shirt, pants and shoes), as per their care plan and the home's policy. [s. 40.]

WN #17: 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. (3) Despite subsection (1), a licensee may hire as a personal support worker or to provide personal support services,
(a) a registered nurse or registered practical nurse,
(i) who, in the opinion of the Director of Nursing and Personal Care, has adequate skills and knowledge to perform the duties of a personal support worker, and
(ii) who has the appropriate current certificate of registration with the College of Nurses of Ontario;
(b) a person who was working or employed at a long-term care home as a personal support worker at any time in the 12-month period preceding July 1, 2011, if,
(i) the person was working as a personal support worker on a full-time basis for at least three years during the five years immediately before being hired, or
(ii) the person was working as personal support worker on a part-time basis for the equivalent of at least three full-time years during the seven years immediately before being hired;
(c) a person who is enrolled in an educational program for registered nurses or registered practical nurses and who, in the opinion of the Director of Nursing and Personal Care, has adequate skills and knowledge to perform the duties of a personal support worker;
(d) a person who is enrolled in a program described in subsection (2) and who is completing the practical experience requirements of the program, but such a person must work under the supervision of a member of the registered nursing staff and an instructor from the program;
(e) a person,
(i) who has a diploma or certificate granted in another jurisdiction resulting from a program that was a minimum of 600 hours in duration, counting both class time and practical experience time,
(ii) who has a set of skills that, in the reasonable opinion of the licensee, is equivalent to those that the licensee would expect of a person who has completed a program referred to in clause (2) (a), and

(iii) who has provided the licensee with proof of graduation issued by the education provider;
(f) a person who is enrolled in a program that is a minimum of 600 hours in duration, counting both class time and practical experience time, and meets,
(i) the vocational standards established by the Ministry of Training, Colleges and Universities,
(ii) the standards established by the National Association of Career Colleges, or
(iii) the standards established by the Ontario Community Support Association, but such a person must work under the supervision of a member of the registered nursing staff and an instructor from the program; or
(g) a person who, by July 1, 2018, has successfully completed a personal support worker program that meets the requirements set out in clause (f), other than the requirement to work under supervision, and has provided the licensee with proof of graduation issued by the education provider. O. Reg. 399/15, s. 1.

Findings/Faits saillants :

1. The licensee has failed to ensure that, on or after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, was hired in accordance with the requirements in O. Reg. 79/10, s. 47.

O. Reg. 79/10, s. 47 (3) (c) identifies that the home may hire a person who is enrolled in an educational program for registered nurses or registered practical nurses and who, in the opinion of the Director of Nursing and Personal Care, has adequate skills and knowledge to perform the duties of a personal support worker.

O. Reg. 79/10, s. 47 (4) (a) identifies that the licensee must cease to employ as a personal support worker, or as someone who provides personal support services, regardless of title, a person who was required to be enrolled in a program described in clause (3) (c) or (d) if the person ceases to be enrolled in the program or fails to successfully complete the program within five years of being hired.

Inspector #625 reviewed a document provided by Scheduler #116, which identified that PSW #130 had worked in the home from June 25 to July 31, 2018.

Inspector #625 reviewed PSW #130's employee record which included:

- a resume which listed that PSW #130 had been enrolled in a Bachelor of Nursing program at the University College of the North/University of Manitoba from "Sept 2013 – Present"; and
- a letter dated June 25, 2017, signed by the Nursing Program Coordinator at University College of the North, which identified the PSW to have completed theoretical and clinical content in the Bachelor of Nursing Program, which allowed the PSW to "provide personal care to clients at a higher level or equivalent to a Health Care Aide working in an institution".

On September 19, 2018, [87 days after PSW #130 began working in the home] during an interview with the ED, they acknowledged that although PSW #130's Bachelor of Nursing Program letter was dated from June 2017, [and the PSW had worked in the home one year after the letter was dated], the home had not been provided with proof of the PSW's enrollment in the Bachelor of Nursing Program.

The licensee had failed to ensure that PSW #130 had been enrolled in an educational program for registered nurses or registered practical nurses prior to, and during, the time the PSW worked in the home. [s. 47. (3)]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)

(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact information of a person designated by the Director to receive complaints; 2017, c. 25, Sched. 5, s. 21 (1)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(g.1) a copy of the service accountability agreement as defined in section 21 of the Commitment to the Future of Medicare Act, 2004 entered into between the licensee and a local health integration network;
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(l.1) a written plan for achieving compliance, prepared by the licensee, that the Director has ordered in accordance with clause 153 (1) (b) following a referral under paragraph 4 of subsection 152 (1); 2017, c. 25, Sched. 5, s. 21 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the most recent minutes of the Family Council meetings, with consent of the Family Council was posted in the home, in a conspicuous and easily accessible location.

During the entrance conference interview with the ED, they reported to Inspector #621 that the most recent meeting of Family Council had been in July 2018. The ED subsequently provided the Inspector a copy of the most current Family Council meeting minutes, dated July 25, 2018.

During an interview with Family Council member #111, they identified that the last meeting of Family Council occurred in July 2018, and copies of the minutes were made available in the home.

During a review of the Family Council minutes; posted at the entrance of the home in a white binder, Inspector #621 found the most recent meeting minutes to be from March 20, 2018.

Together, the ED and Inspector #621 reviewed the minutes of Family Council posted in the binder at the entrance of the home. On review of the postings, the ED confirmed to the Inspector that the most recent minutes of Family Council from July 25, 2018, were not posted and available in the home for family and visitor perusal. [s. 79. (3) (o)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

A Critical Incident System (CIS) report was submitted to the Director for an incident of alleged physical abuse of resident #005, which was reported to have occurred on a specific date in February 2018.

Inspector #693 reviewed the CIS report, as well as progress notes for resident #005, and found no information indicating that resident #005's substitute decision maker (SDM) or any other person specified by the resident, was notified within 12 hours of the licensee becoming aware of the alleged abuse.

In an interview with resident #005 they stated to Inspector #693 if there was an incident in which they were harmed or may have been harmed, they would want their emergency contact who was family member #035 to be notified.

During an interview, RN #110 stated that the home's policy for incidents of suspected, alleged or witnessed abuse was to notify their supervisor immediately and then the resident's family member.

A review of the home's policy entitled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting: RC-02-01-02, Appendix 1", last updated April 2017, identified that after the Administrator, Director of Care (DOC) or designate is informed of the suspected abuse, that the substitute decision maker (SDM)/Power of Attorney (POA) or any other individual identified by the resident should be notified.

In an interview, the DOC stated that there was no documentation to show that resident #005's emergency contact was notified of the allegations of abuse made by the resident within 12 hours of the licensee becoming aware, and that they should have been. [s. 97. (1) (b)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of the incident, for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

A Critical Incident System (CIS) report was received by the Director on a specific date in June 2018, concerning resident #006, who had a fall with injury, and was subsequently transported to hospital. The report identified that the fall occurred on another specific date in June 2018, which was 11 days prior to the Director being notified by the home.

A review of the progress notes dated from June 2018, indicated that resident #006 had fallen at a specific time, and later that day, the resident began complaining of pain to specific areas of their body. The progress notes further identified that the resident was sent to hospital and a day later, the home was informed that resident #006 had sustained a specific type of injury and would be transferred to another acute care facility for intervention.

A review of the home's policy titled "Mandatory and Critical Incident Reporting - RC-09-01-06", revised April 2017, indicated that the home was required to inform the Ministry of Health and Long-Term Care, no later than one business day after the occurrence of an incident, where there had been an injury to a resident for which the resident was taken to the hospital and resulted in a significant change in the resident's health condition.

During an interview with the DOC, they confirmed to Inspector #577 that the home had not notified Director within one business day of the home being made aware of resident #006's injury. [s. 107. (3) 4.]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirements were met where a resident was restrained by a physical device under section 31 of the Act: That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

During afternoon and evening observations of resident #001 on a day in September 2018, the resident was observed by Inspector #577 to be seated in a wheelchair with a safety device engaged.

A review of resident #001's care plan did not indicate any information related to the use of a safety device. A review of the physician orders did not identify any orders for a safety device. Additionally, there was not a restraint or Personal Assistance Service Device (PASD) assessment, nor a consent on the resident's chart.

A record review of the home's policy titled "Least Restraints – RC-22-01-01", revised February 2017, identified that staff were required to obtain a physician's order for the restraint, which specified the type of restraint used, when the restraint should have been used and how long the restraint would be used for. Further, the policy indicated that restraints would only be implemented with an order and upon consent.

During an interview with resident #001, Inspector #577 asked the resident if they were able to latch the safety device. Resident #001 demonstrated to the Inspector, and also reported to them that they could not secure the safety device.

During an interview with PSW #139, they reported that resident #001 should not have had a safety device engaged while they were in their wheelchair, and

proceeded to disengage the safety device from the resident.

During an interview with RPN #141, they reported that restraints and PASD's were not listed in the resident's care plan and that resident #001 did not use a safety device. Additionally, RPN #100, reported to Inspector #577 that resident #001 did not use a safety device and the resident was probably given an available wheelchair from the home that already had a safety device on it.

During an interview with PT #124, they reported to Inspector #577 that resident #001's wheelchair was from the home and the resident did not wear the safety device that was present.

During an interview with the DOC, they confirmed with Inspector #577 that resident #001 should not been using a safety device.

During an interview with the ED, they reported to the Inspector that a safety device should not have been used with resident #001. [s. 110. (2) 1.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. TThe licensee has failed to ensure that drugs remained in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

During a specific day and time in September 2018, Inspector #196 observed the medication administration for resident #035 as completed by RN #142. The RN was observed to open the plastic package labeled with the resident name and the drug name, and then proceed to dispense the medication into a paper cup. RN #142 then proceeded to the resident's room and upon identifying that the resident was not on the unit, placed the paper cup with the medication, into one of the medication drawers and locked the cart. RN #142 then informed the Inspector that they would wait for the resident to come back to the unit and give it to them then.

At a specified time, the Inspector met with the RN #142 on the unit, who stated that they were going to take the medication to resident #035, where they were situated. The RN was then observed by the Inspector to remove the paper cup containing the pre-poured medication out of the drawer, and take it to the resident. The medication was not administered from the original labeled package that was provided by the pharmacy service provider.

The Inspector reviewed the home's policy titled "Medication Management - RC-16 -01-07", last updated February 2018. The policy read "Keep medications in the original labeled container(s) or packages(s) provided by the pharmacy service provider or the Government supply until administered to a resident."

During an interview with the DOC, they reported to the Inspector that RN #142 had not followed the homes' policy for medication administration, in that they had not kept medications in the original labeled package as provided by the pharmacy service provider. [s. 126.]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspector #196 reviewed a medication incident report (MIR) which indicated that resident #035 had not been administered a dose of prescribed medication at a specific time, on a specified date in April 2018. The medication incident report indicated that a scheduled dose of this medication had been signed off as administered in the electronic medication record (e-MAR), but the package that contained the drugs was found in the medication cart.

Inspector #196 reviewed the policy titled "Medication Management - RC-16-01-07", revised February 2018, which identified that staff were to ensure that all residents were given their medication and the documentation was done upon completion of the medication pass.

During an interview with the DOC, they reported to the Inspector that resident #035 did not receive their medication at the required date and time, as had been prescribed by their medical provider. They added that the RPN had signed to indicate it had been given prior to the medication administration. [s. 131. (2)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was, reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Inspector #196 reviewed a medication incident report (MIR) which indicated that resident #035 had not been administered a dose of a prescribed medication at a specific time, on a specified date in April 2018. The medication incident report indicated that a scheduled dose of this medication had been signed off as administered in the electronic medication record (e-MAR), but the package that contained the drugs was found in the medication cart.

The MIR and the resident's progress notes were reviewed and they did not

indicate that the medication incident had been reported to the resident, the resident's substitute decision-maker, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident.

Inspector #196 reviewed the home's policy titled "Medication Incident and Reporting - RC-01-09", last updated February 2017. The policy read "Progress notes should have a factual account of what happened and what was done in relation to the medication incident", "Take immediate action in the event of an incident/adverse drug event by notifying the physician/nurse practitioner for treatment directions"; and "Communicate all medication incidents/adverse drug events to the POA/Substitute Decision Maker/family".

During an interview with the DOC, they reported to the Inspector that the family, the resident, the attending physician and the homes' medical director had not been notified of the medication incident. [s. 135. (1)]

2. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

Inspector #196 reviewed the homes' "Professional Advisory Meeting" minutes dated August 29, 2018, for the reporting period of April - June 2018. The written meeting minutes indicated the numbers of medication incidents that had occurred each month in the three month time period, but did not identify a review had been done in order to reduce and prevent medication incidents and adverse drug reactions.

During an interview with the DOC, they reported that the numbers of incidents as indicated in the meeting minutes were not accurate and that there was no analysis of the incidents, except to identify if an incident was an omission or the nature of the occurrence. [s. 135. (3)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program; O. Reg. 79/10, s. 229 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an interdisciplinary team approach in the co-ordination and implementation of the infection prevention and control program required under subsection 86(1) of the Act.

During the inspection, Inspector #621 observed contact precaution signage posted on a resident room door, which identified that staff and visitors were to wear personal protective equipment (PPE) when performing direct care with the resident, and perform hand hygiene as per routine practices, including before entry and on leaving the room. The Inspector however, found no supply of the required PPE in proximity to the room.

During interviews with PSW #112 and RPN #125, they reported to Inspector #621 that over a specific period to time, a Housekeeping Aide took down the contact precaution signage and PPE outside of two resident rooms, and informed unit staff it was no longer required. Neither PSW #112 or RPN #125 were able to identify to the Inspector the reason why the contact precautions had been deemed to be no longer necessary. RPN #125 also identified that they were on duty at the time of the incident, but had not investigated the issue further with the RN on duty or DOC. RPN #125 indicated that infection, prevention and control measures were in place for resident #006, and resident #029.

During a further observation of the resident, Inspector #621 found neither room stocked with the required PPE. Also, there was no contact precaution signage posted on one of the resident's rooms to alert staff and others of the need to observe Infection Prevention and Control (IPAC) precautions when entering resident #029's room.

Inspector #621 reviewed the home's policies, last updated September 2017,

which identified that specific pathogens were highly contagious infections spread through touch and contamination which, once detected in the home, required rigorous attention and precautions to stop the spread of the infection to other residents and/or staff. Additionally, the policy indicated that residents with known risk factors, symptoms or a confirmed history of infection were to be place on contact precautions; staff and visitors were to perform proper hand hygiene; and required PPE was to be made available.

During an interview with the DOC, they reported to Inspector #621, that there was a gap in staff knowledge of the home's IPAC program which needed to be addressed. They reported that resident #005 had been confirmed with a specific type of infection, and had an active order on the chart for contact precautions. The DOC reported that there had been no change to this residents contact precaution requirements, and it was expected that a PPE caddy be on the resident's door, appropriately stocked for use by staff and any visitors. The DOC also identified that resident #029 was confirmed to have a specific type of infection according to their chart. The DOC also confirmed with the Inspector that contact precaution signage was no longer present at the entrance of resident #029's room; that the PPE caddy that was present, but was not adequately stocked.

During an interview with the ED, they identified to Inspector #621 that they expected an inter-collaborative care approach to implementing and maintaining the home's IPAC program with resident care and that they expected more accountability from professional staff in this regard. [s. 229. (2) (a)]

Issued on this 14th day of November, 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JULIE KUORIKOSKI (621) - (A1)
Inspection No. / No de l'inspection :	2018_740621_0023 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	005682-18, 013711-18, 013722-18, 013723-18 (A1)
Type of Inspection / Genre d'inspection :	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 14, 2018(A1)
Licensee / Titulaire de permis :	CVH (No. 2) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Birchwood Terrace 237 Lakeview Drive, R.R. #1, KENORA, ON, P9N-4J7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pat Stephenson

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Ontario

Ministry of Health and Long-Term Care

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 : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_624196_0012, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must be compliant with s.8(3) of the LTCHA.

The licensee shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

Grounds / Motifs :

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

The licensee has failed to comply with compliance order (CO) #001 from inspection #2018_624196_0012, served on June 1, 2018, with a compliance date of July 31, 2018.

The order required the licensee to ensure the following:
"The licensee must be compliant with the Long-Term Care Homes Act, 2007, c. 8, s. 8 (3)" ; and
The licensee must ensure that at least one registered nurse who is both an employee

of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations."

Inspector #625 reviewed nursing staff sign-in sheets for a time period between July and September 2018. On a specific day and shift in August 2018, the sign-in sheet indicated that RN #115, who was an agency RN, had worked as the only RN in the building.

During interviews with Scheduler #116, they stated that RN #115 was an RN employed through a staffing agency, and had been the only RN working in the home during a specific shift on a certain day in August 2018, due to an empty rotation.

During an interview with the Executive Director (ED), they stated that RN #115 had been employed by the home through a staffing agency and had worked alone during a specific shift, on a certain day in August 2018.

The decision to re-issue the Compliance Order and Director's Referral was made due to the severity which was a level 2 as there was minimal harm or potential for actual harm to the residents. The scope was level 3 as it affected all residents in the home. The compliance history was a level 4 as there were ongoing related non-compliance that included:
- a Compliance Order (CO) and Director's Referral issued under s.8(3) of the Long-Term Care Homes Act (LTCHA) 2007, on June 1, 2018, in report #2017_624196_0012, with a compliance date of July 31, 2018;
- a CO issued under s.8(3) of the LTCHA 2007, on August 3, 2017, in report #2017_652625_0010, with a compliance date of September 4, 2017;
- A CO issued under s.8(3) of the LTCHA 2007, on March 8, 2017, in report #2017_633577_0002, with a compliance date of March 22, 2017;
- a Voluntary Plan of Correction (VPC) issued under s.8(3) of the LTCHA 2007, on July 12, 2016, in report #2016_246196_0009; and
- a VPC issued under s.8(3) of the LTCHA 2007, on January 21, 2016, in report #2016_339617_0004. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 08, 2019(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall 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,
(a) is in compliance with and is implemented in accordance with all applicable requirements under the Act; and
(b) is complied with. O.Reg, 79/10, s.8(1).

The licensee must also comply with the Long-Term Care Homes Act (LTCHA), c.8, s.21, which identifies that every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

Grounds / Motifs :

1. The licensee has failed to ensure that, where the LTCHA, 2007 or O. Reg. 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was complied with.

The Long-Term Care Homes Act, 2007, c. 8, s. 21 identifies that every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

During resident interviews, resident's #013 and #014 informed Inspector's #625 and #577 respectively that a specified amount of their money had went missing over a certain period of time.

Inspector #625 reviewed the home's policy titled "Complaints and Customer Service – RC-09-01-04", last updated April 2017, which identified that the home would track and resolve concerns and complaints in a fair and timely manner and take steps to address root causes and contributing factors in order to prevent recurrence. The policy identified that verbal complaints were to have investigations immediately initiated where possible, (i.e., complaints about missing laundry, missing glasses, etc.). The policy also identified that "Appendix 1 - Complaint Investigation Form" was to be completed in detail if the complaint could not be resolved within 24 hours, and forwarded to the Administrator/department manager. The policy further identified that "Appendix 5 - Complaint Log" was to be used to maintain a record of all complaints and actions taken, and the home was to monitor the resolution of concerns/complaints monthly to identify trends and opportunities for quality improvement.

Inspector #625 reviewed the home's completed "Appendix 5 - Complaint Log" for 2018, which identified on a specific day in April 2018, resident #033 had complained that a specified amount of money was missing from their possession. The "Summary of Actions Taken" section of the log identified that the resident was re-educated on the importance of keeping their money locked up in the main office until they needed it to make a purchase. Another complaint from resident #034, related to missing money from another day in April 2018, indicated that the resident believed their roommate had taken a specified amount of money from them. The "Summary of Actions Taken" section of the log identified that the home was unable to determine if resident #034's roommate had taken their money, and resident #034 was educated by the home on ensuring their wallet and money was kept in the office for safe keeping.

During an interview with PSW #118, they stated that they were aware that residents

#017 and #035 had reported missing money in 2018, but were not aware that resident #014 had money missing. PSW #118 however, identified that resident #014 was a reliable historian and would be able to keep track of something like that. Further, the PSW stated that when a resident reported money missing, they would look for the money and tell the RN if it could not be found.

During an interview with PSW #112, they stated that resident #036 had reported that a specific amount of money and a piece of jewellery went missing over a specified period of time. The PSW also stated they had looked for the items, but had not located them, and that they had reported it to a nurse on duty.

During an interview with RPN #106, they stated that when a resident's money was reported missing, they would look for it, fill out a complaint form, and chart on it. The RPN identified that they were not aware that a number of residents including, #013, #014, #017, #033 or #035 had reported missing money, however they stated that they would believe resident #017, as they had a good memory; that resident #013 would know; and that resident #014 would also probably know if their money went missing.

During an interview with RPN #119, they stated that they were aware that resident #013 had reported missing a certain amount of money, and that they had notified the resident's family, who wasn't sure if the resident had that much money with them. The RPN also stated they were not aware that resident #036 had reported money missing over a specific period of time. Further, RPN #119 indicated that when there was a complaint made by a resident of missing money, that they would call the laundry department, complete a chart note, and notify the family. Additionally, RPN #119 identified that when family reported missing money, they would fill out a complaint form and forward it to the Director of Care (DOC). The RPN indicated that residents sometimes went to the main office directly to let the home know of missing money, and as a result staff on the unit would not always know.

During an interview with RN #110, they stated that they would fill out the home's "Complaint Investigation Form" and document in the progress notes of the residents electronic health record, when items including money, were reported missing by residents. RN #110 identified that they knew resident #035 had reported missing money, but could not recall if it was on a shift they had worked on, or if the information had been passed onto them. The RN showed Inspector #625 a binder

which contained blank "Complaint Investigation Forms", which the RN stated were to be completed when money was reported missing, with completed forms submitted to the DOC. RN #110 acknowledged that one form dated from 2017, had been only partially completed, which identified a resident was missing a specific amount of money.

During an interview with Scheduler #116, who also handled residents' money, they stated to Inspector #625 that they had heard resident #013 was missing money as the resident had come down to the office about it.

Inspector #625 reviewed progress notes for resident's #013, #014 and #037, but was unable to locate any documentation related to the issue of missing money being reported by the residents.

Inspector #625 also reviewed progress notes for resident #017 and identified a note from April 26, 2018, by the Registered Social Worker (RSW), which indicated the resident brought up the issue of having lost a specified amount of money over the previous weekend; that the RSW found a hole in the bottom of the resident's money pouch, and proceeded to stitch up the pouch "to ensure no money fell out in the future".

A review of progress notes for resident #035, identified an entry dated from April 2018, which detailed the resident's complaint of missing a specified amount of money; that the resident told one of the staff to put the money in their top drawer; and that the money was not there later that day.

Additionally, a review of progress notes for resident #033, identified an entry dated from a specific day in February 2018, by the RSW, which identified resident #033 spoke to the RSW about a situation where resident #014 accused resident #033 of knowing who had taken the money from their room. The entry further identified that the RSW provided the resident with coping strategies and confirmed that resident #033 had used "good assertiveness skills" to address resident #014's comments.

During an interview with Inspector #625, the DOC stated that they had not received any paper copies of the home's Complaints Investigation Forms in 2018, and specifically identified that they had not received any complaints regarding missing money. The DOC also acknowledged that the home's complaints policy had not been

followed by staff with respect to verbal complaints of missing money in the home.

During interviews with Inspector #625, the ED stated that money probably went missing from the home daily and that the home wouldn't do much if it was a small amount. The ED further stated they had not been told of any missing resident money by staff since they assumed the role of ED in the home, and could not locate any additional complaint forms related to missing money, except for what was listed in the home's completed "Appendix 5 – Complaint Log" for 2018. The ED confirmed that the home's Complaints and Customer Service policy should have been followed for missing money, but that it had not been.

The decision to issue the Compliance Order was made due to the severity which was a level 2 as there was minimal harm or a potential for actual harm to the residents. The scope was a level 3 as the identified deficiency was pervasive in the home. The compliance history was a level 3 as there was one or more related non-compliance with this area of legislation which included the following:
- a Voluntary Plan of Correction (VPC) issued under r.8(1)(b) of O.Reg 79/10, on January 10, 2018 in report #2016_512196_0015; and
- a VPC issued under r.8(1)(b) of O. Reg 79/10, on August 25, 2016, in report #2016_246106_0010. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 08, 2019(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Order / Ordre :

The licensee to ensure that there is a written staffing plan for the organized programs of nursing services and personal support services referred to in O. Reg. 79/10, s. 31. (1) (a) and (b), in accordance with O. Reg. 79/10, s. 31 (2).

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written staffing plan for the organized programs of nursing services and personal support services referred to in Ontario Regulation 79/10, s. 31 (1) (a) and (b).

On June 1, 2018, CO #001 from inspection #2018_624196_0011 was served pursuant to the LTCHA, 2007, c. 8, s. 8 (1) (b). Step (b) of the order required the licensee to ensure that there was a written staffing plan for the organized programs of nursing services and personal support services referred to in O. Reg. 79/10, s. 31. (1) (a) and (b), in accordance with O. Reg. 79/10, s. 31 (2). Step (c) of the order required the licensee to ensure that the staffing plan was developed and implemented in consideration of O. Reg. 79/10, s. 31 (3) and (4).

During an interview with Inspector #625, Scheduling Clerk #116 identified that the home had a total of 15 filled and 26 vacant PSW positions. They stated that the usual staffing complement was eight PSWs on the day shift, eight PSWs on the evening shift and four PSWs on the night shift, but that the home had been staffing with fewer PSWs due to the lower occupancy rate. Scheduling Clerk #116 stated that, with the lower occupancy rate, the home was being staffed with seven PSWs on both day and evening shifts.

Inspector #625 reviewed Personal Support Worker (PSW) sign-in sheets for a specific time period between July and September 2018. The sheets identified that the home had employed agency staff to work as PSWs; that agency staff worked 59 out of 60, (or 98 per cent), of the dates reviewed; and the home scheduled up to five agency PSWs to work in one day. The sheets also identified that in spite of regular shifts being eight hours (hrs) in duration, with day shifts occurring from 0700 to 1500 hrs; evening shifts from 1500 to 2300 hrs; and night shifts from 2300 to 0700 hrs, home's staff and agency staff had worked up to 16 hrs on 26 out of 50 days, in order to staff the home, while working with less than the required staff complement.

During an interview, Inspector #625 and the ED reviewed O. Reg. 79/10, s. 31 with a focus on the written staffing plan and the requirements of the plan as per subsections (2) and (3). The ED identified that the home did not have a written staffing plan required pursuant to O. Reg. 31 (2). The ED acknowledged that the home had not completed the written staffing plan and stated that the plan was being developed to include staffing model changes.

The decision to issue a Compliance Order was made due to the severity which was a level 2 as there was minimal harm or a potential of harm to the residents. The scope was a level 3 as it affected all residents in the home. The compliance history was a level 3 as there previous related non-compliance with this area of the legislation, including:
- a Voluntary Plan of Correction (VPC) issued under r.31(2) of O. Reg 79/10, on June 1, 2018, in report #2018_624196_0011. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 08, 2019(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c.8, s.20(1).

Grounds / Motifs :

1. The licensee has failed to ensure that, without in any way restricting the generality of the duty provided for in section 19, there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

Inspector #625 reviewed the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", last updated April 2017, which indicated that staff were to complete an internal incident report and notify their supervisor of witnessed or suspected abuse or neglect; and management would promptly and objectively report all incidents to external regulatory authorities, including the police if there were reasons to believe a criminal code offence had been committed.

The Inspector also reviewed appendices to the policy including:
(1) "Abuse and Neglect Decision Tree", last updated April 2017, which indicated that "Supervisor immediately reports to the Administrator/DOC/designate", "Notify SDM/POA or and other individual identified by the resident"; and "Proceed to appropriate Ontario LTC decision tree and submit a CIS Report";
(2) "Jurisdictional Reporting Requirements" last updated April 2017, which identified,

in Ontario, mandatory reporting required a person to make an immediate report to the Director where there was a reasonable suspicion that certain incidents occurred or may occur, which included "Misuse or misappropriate of a Resident's money"; (3) "Ontario LTC Financial Abuse Decision Tree" last updated April 2017, which identified that, if there were reasonable grounds to suspect that financial abuse had occurred or may have occurred, the licensee was to determine if a resident's money or property was misused or misappropriated. If it was, the licensee was to immediately report the suspicion and information to the Director, followed by completion of a Critical Incident System (CIS) report including the results of an investigation and actions taken in response to the incident by identified timelines.

Further, Inspector #625 reviewed the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", last updated April 2017, which identified that staff were to refer to the "Abuse and Neglect Decision Tree - Appendix 1", last updated April 2017, which indicated that staff were to proceed to the appropriate Ontario LTC decision tree and submit a CIS report, which included Appendix 8 - Ontario LTC Financial Abuse Decision Tree.

During resident interviews, residents #013 and #014 stated to Inspectors #625 and #577, respectively, that they had missing money.

During an interview with the Registered Social Worker (RSW) regarding resident finances in the home, they stated that residents #030 and #031 had been financially abused while residing in the home.

Inspector #625 reviewed the progress notes for resident #030 which included notes from specific dates in July and September 2017, which referred to suspicions and beliefs that the resident was being financially abused, as well as actions the home implemented to limit further financial abuse.

Inspector #625 also reviewed progress notes for resident #031 which included notes from specific dates in December 2016, March 2017, and September 2018, which referred to suspicions and beliefs that the resident was being financially abused, as well as actions the home implemented to limit further financial abuse.

Inspector #625 searched intakes associated with Critical Incident System (CIS) reports submitted from the home for dates between January 2016, and September

2018, and was unable to locate a corresponding intake for resident #030 or resident #031, where the Director had been notified of suspected financial abuse of either resident, including information to support the suspicion, investigation details, actions taken by the home, or the results of the investigation.

During a second interview with the RSW, they acknowledged to Inspector #625 that there had been a reasonable suspicion that financial abuse had occurred towards residents #030 and #031 but that neither suspicion had been reported to the Director, although both allegations had been discussed during the home's leadership meetings. The RSW stated they had never been informed that the Director would have to be notified of the abuse. Further, the RSW acknowledged that the financial abuse should have been reported to the Director and that they would have reported it had they known it was required. Lastly, the RSW reviewed the "Ontario LTC Financial Abuse Decision Tree" with the Inspector and acknowledged that the home's policies related to abuse had not been followed.

During an interview with the ED, they stated to Inspector #625 that financial abuse involving residents #030 and #031 had occurred and that suspicions of abuse of both residents should have been reported to the Director. The ED was not able to locate a CIS report for either resident related to the suspicion of financial abuse. The ED stated that the home's abuse policies had not been followed. (625)

2. A complaint was received by the Director on a day in July 2018, alleging staff to resident neglect of residents' #024, #025 and #026.

During an interview with the staff member #113, they identified to Inspector #621 that they had suspicions of neglect of residents' #024, #025 and #026 by staff member #114 and decided to make a report to the Ministry of Health and Long-Term Care (MOHLTC) about their concerns. When the Inspector asked about the home's policy for mandatory reporting of suspected abuse or neglect, staff member #113 identified that consistent with the home's policy, staff were to immediately report their suspicions to their reporting manager/designate, who would then follow up with the Administrator and/or DOC. When the Inspector inquired with staff member #113 if they had immediately reported their suspicions of neglect of the three residents to their reporting manager/designate utilizing the home's policy for mandatory reporting, they identified that they had not.

Inspector #621 reviewed a copy of the home's policy entitled "Zero Tolerance of

Resident Abuse and Neglect: Response and Reporting – RC-02-01-02", last updated April 2017, which identified that anyone who witnessed or suspected abuse or neglect of a resident by another resident, staff or other person must report the incident immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior supervisor on shift at that time. Additionally, the policy identified that the person reporting the suspected abuse would follow the home's reporting process and provincial requirements to ensure the information was provided to the home Administrator/designate immediately.

During an interview with the DOC, they reported to Inspector #621 that if a staff member witnessed, or knew of alleged or suspected abuse or neglect of a resident, it was expected that the staff member would follow the home's mandatory reporting policy and immediately notify the RN on duty; who would then immediately make a report to the DOC and/or Administrator, and follow the home's policy to contact the Ministry of Health and Long-Term Care (MOHLTC). The DOC stated that if it was after-hours, the RN on duty would immediately make the report to the Manager on-call, who would then notify the DOC and/or Administrator, and contact the MOHLTC after-hours pager. The DOC confirmed with Inspector #621 that the home had not received a report from anyone, including home's staff with regards to suspected neglect of resident #024, #025 or #026.

The decision to issue the Compliance Order was made due to the severity which was a level 2, as there was minimal harm or a potential for actual harm to the residents. The scope was a level 2 as there was a pattern of staff not following the home's zero tolerance of abuse and neglect policy with regards to their reporting obligations. The compliance history was a level 3 as there was previous non-compliance with this area of legislation, including:
- a Voluntary Plan of Correction (VPC) issued under s.20(1) of the Long-Term Care Homes Act (LTCHA) 2007, on August 3, 2017, in report #2017_625625_0010;
- a VPC issued under s.20(1) of the LTCHA 2007, on March 1, 2017, in report #2017_633577_0003; and
- A VPC issued under s.20(1) of the LTCHA 2007, on January 10, 2017, in report #2016_512196_0015. (621)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 08, 2019(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

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

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

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

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 Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 14th day of November, 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JULIE KUORIKOSKI (621) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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