Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 18, 2018;	2017_555506_0027 (A4)	027381-17	Resident Quality Inspection

Licensee/Titulaire de permis

Blackadar Continuing Care Centre Inc.
101 Creighton Road DUNDAS ON L9H 3B7

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

Blackadar Continuing Care Centre
101 Creighton Road DUNDAS ON L9H 3B7

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

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Amended by BERNADETTE SUSNIK (120) - (A4)

Amended Inspection Summary/Résumé de l'inspection modifié

The 7 requirements under compliance order #005 were missing and were added the public report.

Issued on this 18 day of June 2018 (A4)

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

Original report signed by the inspector.

Ontario

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Amended by BERNADETTE SUSNIK (120) - (A4)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): December 4, 5, 6, 7, 8, 12, 13, 14, 15, 18 and 19, 2017.

During this inspection the following inspections listed below were conducted concurrently:

Complaints

002128-17- related to staffing and 24 hour registered nurses

013089-17- related to resident charges

017569-17- related to resident charges

022817-17- temperatures in the home

Critical Incidents

016784-16- personal support services and improper transferring

025324-16- abuse and neglect

027779-16- abuse and neglect and improper transferring

034306-16- resident to resident abuse and neglect

005179-17- staff to resident abuse

007651-17- staff to resident abuse

023967-17- fall prevention and management

Inquiries

005935-17- missing and lost items

023990-17- unexpected death

During the course of the inspection, the inspector(s) spoke with Administrator, former Administrator, Director of Care (DOC), former DOC, interim DOC, Quality Co-ordinator nurse, Minimum Data Set Resident Assessment Co-ordinator (MDS RAI), Pharmacist, Physiotherapist, Nursing Clerk, Office Manager, Dietary and Environmental Service Manager (ESM), Maintenance, Resident Program Manager, housekeeping staff, laundry staff, dietary staff, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), former PSWs, families and residents.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, observed medication passes, reviewed clinical records, policies and procedures, the home's complaints process, staffing schedules, investigative notes and conducted interviews.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

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.

22 WN(s)
14 VPC(s)
6 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 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 failed to ensure that there was at least one Registered Nurse who was an employee of the licensee and was a member of the regular nursing staff on

duty and present at all times.

A. Blackadar is a long term care home with a licensed capacity of 80 beds. The planned staffing pattern for registered nursing staff in the home, for the direct care of residents, was three RNs for a total of 24 hours a day, as identified on work schedules provided by the home and confirmed by the Administrator.
During an interview on an identified date in December 2017, with the Administrator and the Nursing Clerk identified that, the home did not have a sufficient number of RNs within the staffing plan to fill all the shifts related to staffing events such as sick calls. The Administrator and the Nursing Clerk confirmed that the home consistently offered additional shifts to regular registered nurses to fill these vacant shifts; however, when the registered nurses employed by the home were unwilling or unable to work one or more of the required shifts the home would fill those shifts with registered nurses employed with an employment agency. On request the home provided a list of shifts from December 2016, until November 2017, which identified there were 37 occasions where agency registered nurses worked to ensure that a registered nurse was on site 24 hours a day. The Administrator and Nursing Clerk confirmed that the need to fill these RN shifts were not the result of emergency situations as outlined in O. Reg 79/10, s. 45(2).
The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times.
B. Review of the home's schedules from December, 2016, until November 2017, identified that there were dates when there was no RN in the building and the home used an employment agency to replace the RN with a registered practical nurse (RPN) or one of the home's RPN's.
i.On an identified date in January 2017, the home used an agency RPN for the evening shift.
ii.On an identified date in January 2017, the home used an RPN that worked at the home for the day shift.
iii.On an identified date in January 2017, from 1930 hours until 2245 hours there was no RN in the home.
iv.On an identified date in April 2017, the home used an agency RPN for the night shift.
v.On an identified date in June 2017, the home used an agency RPN for the night shift.
vi.On an identified date in July 2017, the home used an agency RPN for the evening shift.
vii.On an identified date in September 2017, from 1545 hours until 1900 hours

there was no RN in the home.
The Administrator and the Nursing Clerk confirmed that the employment agency did not have an RN available to replace the RN shifts and therefore used an agency RPN or an RPN that worked at the home to cover the shifts.
The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that residents were transferred using safe transferring and positioning techniques.

i. On an identified date in 2016, resident #018 was in the roomwith PSW #124 and the resident slid down to the floor. An interview with PSW #124 confirmed that they were assisting the resident by themselves and another PSW was outside the room. A review of the care plan and interview with the Quality Co-ordinator nurse confirmed the resident was always a two person transfer.
ii. On an identified date in 2016, resident #018 was complaining of pain to an identified area. PSW #121 in an interview confirmed that during morning care

resident #018 was transferred by one staff to their medical device and the resident was not weight bearing well and needed to be lowered to the ground. PSW #121 confirmed with the Long Term Care (LTC) Inspector on an identified date in 2017, that the resident was a two person transfer but they transferred the resident by themselves. PSW #121 confirmed as well that when the resident was lowered to the ground the PSW did not go and get the registered staff to assess the resident immediately for any injuries as the registered staff was busy at the time. The registered staff was not made aware of what happened until the resident was found in pain. At this time the resident was sent to the hospital for assessment and it was confirmed that the resident sustained an injury. In an interview with the former DOC of the home on an identified date in 2017, confirmed that the resident was not transferred using safe transferring techniques.

iii. PSW #126 did not use safe transferring and positioning techniques while transferring resident #019. On an identified date in 2016, RPN #125 observed PSW #126 transferring resident #019 by themselves. The resident's plan of care indicated that the resident was a two person transfer. The RPN confirmed in an interview on an identified date in 2017, that the PSW was struggling with the transfer as the resident was not pivoting and unsteady on their feet and the resident was falling towards them and the PSW had to push the resident firmly so they would not fall. The RPN confirmed that the PSW did not use safe transferring and positioning techniques while transferring the resident.

iv. On an identified date in 2017, resident #001 was receiving care by PSW #105. The PSW turned away from the resident and had their back to the resident, when the PSW returned the resident had fallen to the floor sustaining superficial injuries to two identified areas. The care plan indicated that the resident when left unattended was to have specific interventions in place. The interim DOC at the time of this inspection confirmed on an identified date in 2017, that the resident was not left in a safe position as the specific interventions were not put in place. [s. 36]

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 LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. As part of the organized program of maintenance services under clause LTCHA, 2007 s. 15(1)(c) of the Act, the licensee failed to ensure that the home, furnishings and equipment were maintained in a good state of repair.

1. The terrazzo flooring material (made of chips of marble, quartz or granite poured with a cementitious binder) in the kitchen dish wash area and in both shower areas was in poor condition. The cementitious binder had eroded, with chips of rock exposed and the surface rough. Evidence of previous filler was noted where repairs were attempted in the past. The flooring material could not be cleaned or disinfected and water was observed pooling in the hundreds of crevices.
2. The bath tub located on an identified home area was observed to have a missing spray nozzle for the disinfectant hose attached. According to PSWs, the nozzle had been missing for over four years. According to the ESS, a company was hired to inspect the bath tubs, but did not identify the disrepair.
3. Bathroom sink faucets were corroded in identified rooms, a rusty sink drain was observed in an identified room, rusty grab bars were observed in two identified areas, a rusty base was observed on an over bed table in an identified room and a damaged foot board was noted on a bed in an identified room.
[s. 15. (2) (c)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, residents were assessed in accordance with prevailing practices to minimize risk to the resident.

A companion guide titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration) provides the necessary guidance in establishing a clinical assessment where bed rails are used. It is cited in a guidance document developed by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards, March 2008" and was identified by the Ministry of Health and Long Term Care in 2012, as the prevailing practice.

Five residents (#005, 017, 044, 045 and 046) were randomly selected during this inspection to determine if they were assessed for bed related safety risks in accordance with the clinical guidelines. A registered nurse, confirmed that they had completed many of the assessments, including several that were reviewed. The assessment was determined to be missing several procedures in identifying the risk over the benefits of bed rail use for residents using one or more bed rails.

A) The licensee's policy and procedure titled "Bed Rail Minimization and Risk Reduction" (RC 08-01-09) dated April 2017, included direction that residents would be assessed by an interdisciplinary care team to determine the continued need for the bed rail on a quarterly basis (where bed rails were previously evaluated and the

resident was previously assessed) and upon admission or change in condition. A form titled the "Bed Rail Entrapment and Risk Assessment (BRERA)" was to be completed by registered staff. The risk reduction policy also referred the reader to a secondary policy titled "Personal Assistance Services Devices (PASD)", which included bed rails, dated February 2017. It directed the interdisciplinary team to trial and document the use of alternatives before applying a PASD (bed rail). It further included the requirement to document the purpose and time frame for the use of the PASD in the resident's written plan of care.

No guidelines or details were included in the risk reduction policy as to how residents would be assessed for risk-related hazards once bed rails were applied. According to the Clinical Guidance document, once bed rails are applied, residents would need to be monitored for sleep patterns, behaviours and other factors while sleeping in bed over a period of time to establish risk-related hazards associated with their bed rails. The licensee's policy would need to establish who was to monitor the residents, for how long and what specific hazards would need to be monitored while the resident was in bed.

No guidelines or details were included in the PASD policy regarding what specific alternatives to bed rails were available for staff to trial with the residents. The alternatives that were listed in the policy included "improved lighting, increased supervision, prompting during the completion of the activity of daily living (ADL), re-enforcement/teaching of technique/method of completing ADL, noise reduction, pain management and adaptive aides. No specific options were listed such as transfer pole, bed rail guards or padding, height adjustable bed, raised perimeter mattress (easier to grab than a flat mattress when being repositioned) or adjustable bolsters (also known as soft rails). Neither policy included what strategies, accessories or options were available to staff and the resident if certain bed safety risks were identified such as suspension, bruising, entanglement or entrapment (for the various different zones).

According to one RN and educator for the home, the process, once residents were newly admitted to the home, was to place the resident in bed without bed rails attached for the first several nights, to get an understanding of whether or not the resident could move about in bed independently and whether they could get in and out of bed independently. The PSWs and night shift RN were tasked at monitoring the residents. This included falls from bed, ability to use the nurse call system, whether they slept soundly or not and other conditions related to pain, comfort and toileting. If the interdisciplinary team all agreed that the resident would benefit from

one or more bed rails, consent would be obtained from the family or resident and the bed rails applied. The RN (or other registered staff) gathered all of the information, including information gathered from the family from the admission process and completed the BRERA form. No risk assessment was formally conducted with residents after they received a bed rail and no documentation was made as to whether there were any bed related risk hazards. When PSWs were asked if they were oriented (actually shown) to the hazards of bed rail use, they replied that no hands on training was received and their knowledge related to bed entrapment was acquired from a computer training module. The PSWs did not have any guidance as to what they were to observe once bed rails were applied such as observing for body parts through the rail (zone 1), bruising or injury against the bed rail, ill-fitting mattresses, loose and ill-fitting bed rails, suspension around a bed rail (if centrally located on the bed) and whether the bed rail was used safely and appropriately.

B) Five out of the five clinical bed safety assessments that were completed within the last 6 months did not include what bed rail alternatives were trialled before the bed rails were applied. The BRERA form did not include an area for the assessor to complete related to alternatives trialled, when applied, for how long and whether successful or not. The residents' clinical records (progress notes) were reviewed and did not include any reference to alternatives trialled.

C) The BRERA form that was used to complete the five resident assessments did not include any information about the residents while asleep after bed rails were applied. The form included three sections. Section A of the BRERA form included questions related to what conditions contributed to a resident's risk of entrapment such as history of bed related injury, communication issues, medical symptoms, history of falls out of bed, ability to self-ambulate, medication use, cognition level and understanding, if agitated, ability to ambulate to and from the bed, body size etc. An area was left open for the assessor to summarize the resident's individual risk for entrapment. Section B of the BRERA form included three questions related to the resident's independence in using the bed rail for positioning and whether they were at risk of entrapment. Section C of the BRERA form included a check list to ensure that the plan of care was updated, what was discussed (alternatives, risk and consent) and what bed rails (if any) the resident would use while in bed. The name of the assessor, names of staff who participated in the assessment, or dates were not listed on the form. For these details, other areas of the resident's electronic record needed to be explored.

D) Mattresses were observed to be ill-fitting on many bed frames located in resident rooms, with and without bed rails in identified rooms. Some of the bed systems were equipped with plastic mattress keepers on each corner of the bed to keep the mattress from sliding off the bed, especially where bed rails were not included. Various reasons were identified as to why these mattresses were found sitting on top of the keepers, either at the head of the bed, foot of the bed or on all four corners. Some mattresses, after the beds were made by staff, did not get pushed back into the keepers, others could only be pushed down into the keepers after the comforter or blanket was removed from the corners of the mattresses and other mattresses were too long to fit properly in an identified room. Mattress keepers were missing from beds in four identified rooms.
Potential entrapment hazards were identified with several beds with either missing mattress keepers or with mattresses sitting on top of the mattress keepers where bed rails were applied. Resident #044 had a medical device applied. The mattress was not secured and was easily pushed askew. The action caused a gap to form in and around the bed rail. Resident #045 was in bed at the time of observation, with their mattress on top of the mattress keepers at the foot end of the bed and a medical device applied. The formation of a gap was a concern if the resident shifted their mattress.

The risk factors associated with bed systems where bed rails were applied and had missing mattress keepers and where mattresses were secured to the bed frame were not considered and incorporated in the resident's clinical assessment (during a sleep observation period).

E) Loose bed rails were noted on several resident beds, creating a condition that could increase bed related injury or entrapment for the resident. For resident #017, who was in bed on an identified date in December 2017, with both medical devices one of the medical devices was noted to be quite loose, creating a large gap between the bedrail and the mattress (end of bed rail). For resident #005, who was not in bed at the time of observation on an identified date in December 2017, one medical device was in use and was very loose, creating a gap. For resident #046, the resident was not in bed at the time of observation on an identified date in December 2017, however, their medical device was loose on one side, which created a large gap between the mattress and bed rail. The loose bed rails were not reported to the registered staff or maintenance staff by either PSWs or housekeeping staff. A housekeeper and several PSWs who were asked if they were aware of the loose bed rails reported that they did not know about their condition and when shown, were not aware of how stiff or loose the bed rails

should have been.

The licensee therefore did not assess residents in accordance with prevailing practices, to minimize risk to the resident. [s. 15. (1) (a)]

Additional Required Actions:

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

(A3)The following order(s) have been amended:CO# 004

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

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,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

(A3)
1. As part of the organized program of housekeeping under clause 15(1)(a) of the Act, the licensee did not ensure that procedures were developed and implemented for cleaning of the home.

i. Numerous portable air conditioning units were observed in the home, located in the windows of various resident rooms which had dusty filters and a black substance that resembled mould on the surface of the directional louvers. The housekeepers reported that they did not clean the air conditioning units. The maintenance person, who had been with the home for just over a year reported that he had not cleaned or inspected the units. According to procedure #2400 located in the maintenance procedures manual provided by the Environmental Services Supervisor, air conditioners were to be cleaned on a monthly basis and

the units were to be inspected for dirt and debris accumulations on the coil fins on a quarterly basis.
ii. Several resident rooms were observed on an identified date in December 2017, were noted to have accumulated dust under and around furnishings, on and under heaters, visible matter on walls in both the bedrooms (near beds) and bathrooms (under vanities and near toilets), dusty ceiling lift spreader bars and motors, dusty exhaust vents in washrooms and cob webbing in corners. In particular, one room had a significant amount of accumulated matter on an over bed table base and on a piece of medical equipment. A return visit was made to the identified rooms on another date in December 2017, and the room sanitation did not appear any different. Several rooms were signed off by a housekeeper as deep cleaned on an identified dates in December 2017, these rooms continued to have a significant amount of soiling on the over bed tables and on the medical device.
According to the home's "Housekeeper 2 and 3 Routine" which broke down tasks by time, high dusting or the need to clean walls in bedrooms was not included, however staff were required to mop the floor, clean furniture and clean various surfaces, including walls in bathrooms. The ESS and housekeeping staff confirmed that two housekeepers were allocated for the three story building at eight hours each per day (minus breaks). Seven hours had to be divided up per housekeeper so that each housekeeper was required to clean 16 resident rooms and ensuite washrooms (four hours if cleaned within 15 minutes), the corridors, stairwells, tub/shower room, nursing station, utility room and dining/lounge room. Once completed, each housekeeper was required to split the cleaning of the lowest level which included two visitor washrooms, hair salon, five offices, corridor, entry foyer, staff change room and washroom, staff lunch room, laundry, activity room, and a large dining room. Not allocated on the daily cleaning schedule was the requirement to deep clean one room per day. According to housekeeping staff, each room was required to be deep cleaned on a daily basis per floor which, depending on the size, took approximately one hour. According to the ESS, the expectation was that during the deep cleaning process, all furniture was supposed to be moved, every surface cleaned and drapes and privacy curtains washed (if soiled).
iii. Tub lift chairs located in the tub rooms were both observed to have a yellow layer of soap scum on the underside of the seats on an identified dates in December 2017. The scum layer was easily removed by the inspector with paper towel. According to PSWs, the cleaning of the chairs was a task assigned to PSWs who gave a tub bath to residents and included cleaning the tub after each bath. Brushes were provided and noted in tub rooms for this task. Cleaning instructions were observed posted on the wall of one tub room and cleaning and

disinfecting procedures were available for tub lift chairs and tubs, which required that they be cleaned and disinfected after each use. One PSW was shown the scum layer of the lift seat in the tub room and stated they would clean it on an identified date in December 2017. However, upon a return visit on another date in December 2017, the layer of scum was still present.
iv. The majority of resident rooms and resident ensuite washrooms were observed to have darkening along the perimeter (along baseboards) of the bedrooms with poly vinyl chloride (VPC) floor tiles and the flooring material appeared dirty, with traffic patterns, scuffs and stuck on debris. The baseboards had old wax, paint and stuck on debris. Certain resident washrooms also had adhesive bleeding out from between the 12 inch VPC floor tiles. According to email records, the Administrator sent a directive to the ESS to have staff remove the adhesive on an identified date in November 2017. However, the ESS reported that the adhesive could not be removed with the method that was employed. Housekeeping staff used brushes and standard cleaning products which did not have an impact on the adhesive. An appropriate adhesive remover was not used.

The home's procedure (05-03-05-A2) included a routine for light floor scrubbing and resurfacing cleaning and a spray buffing frequency for lounges, corridors and resident rooms. The "Floor spray buffing cleaning procedure" required that floors be cleaned (using a floor machine) to remove scuffs, marks and ground in dirt once per month in resident bedrooms. Their floor stripping and re-waxing policies included suggested frequencies for stripping and re-waxing and was based on high or low traffic patterns.

According to housekeeping staff and the maintenance person, no buffing or removal of old wax and re-waxing was scheduled over the last year. During prior years, a rotational schedule had been developed and housekeeping staff reported that floors were stripped and re-waxed. No schedule had been established at the time of the visit to address the floor care issues and the existing procedures were not implemented.

vi. The main kitchen was toured with the ESS on an identified date in December 2017. At that time, heavy matter was splattered on the walls and was noted in and around the steam table in the small servery area and in and around the dish wash area. Heavy build-up of food debris noted on the underside of the stainless steel dish wash table. Moderate amounts of food debris build up noted on the doors of the dish wash machine. Heavy dust accumulation was noted on the screen over the dish wash machine. Heavy scale build-up noted in steam wells of several

steam table units, according to the dietary aide who was tasked at cleaning them, an appropriate de-scaler was not used. Some black spots and food splatter noted on the ceiling. The ESS reported that cleaning of the walls and equipment were on the daily cleaning schedule and were tasked out to various dietary aides and the cook.

Based on the above noted observations, the tasks or procedures were not implemented. [s. 87. (2) (a)]

The licensee failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, procedures were implemented for cleaning of supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

i. It was noted on two dates in December 2017, that resident #003's medical device was unclean. RPN #119 confirmed that the process in the home for the cleaning of resident's personal assistive devices was that Personal Support Workers (PSW) working the night shift were to follow a list of designated resident's personal assistive devices to be cleaned and that resident's personal assistive devices were cleaned two times a month. RPN #119 and observation made by this Inspector on an identified date in December 2017, confirmed that the resident's medical device was heavily soiled with caked on material that could easily be dislodged with the tip of a pen, it was also noted at this time that another area of the medical device was soiled. RPN #119 and this Inspector also observed another one of the resident's medical device and noted the device was soiled in the same manner as the other device.
ii. It was noted on an identified date in December 2017, that resident #006 medical device was unclean. RN #101 and observations made by this inspector confirmed that the areas of the medical device were soiled, there was material on the device that could be dislodged with the tip of a pen. RN #101 provided a copy of the schedule for personal assistive devices cleaning and it was noted that resident #006's medical device was scheduled to be cleaned once a month.
iii. It was noted on an identified date in December 2017, that there was a heavily soiled medical device in the hallway of the home area. RN #101 confirmed that the device belonged to resident #021. RN #101 and observations made by this Inspector confirmed that the device was heavily soiled. RN #101 provided a copy of the schedule for cleaning resident personal assistive devices which indicated the resident's device had been cleaned on an identified date in December 2017.
iv. While reviewing the cleaning schedule RN #101 confirmed that when resident's

personal assistive devices were scheduled to be cleaned, staff were to sign the schedule sheet which confirmed the equipment had been cleaned. The schedule sheet for December 2017, indicated that identified resident personal assistive devices were scheduled to be cleaned on identified dates in December 2017. RN #101 and documentation made by PSWs confirmed that resident's personal assistive devices scheduled for cleaning had not been cleaned. RN #101 indicated they must not have had the staff float for those night shifts and that was why the equipment had not been cleaned. Staff #123 and scheduling documentation confirmed that the scheduled staff float had not worked on the identified dates in December 2017. RN #101 confirmed there was no indication on the cleaning schedule that the personal assistive devices that were scheduled to be cleaned. [s. 87. (2) (b)]

Additional Required Actions:

CO # - 005, 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A4)The following order(s) have been amended:CO# 005

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 cleaning of personal assistive services devices, assistive aids and positioning aids, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe environment for its residents.

A) Four beds were observed without attached foot boards. The removal of the boards related to a variety of reasons and when removed, the metal support brackets were left exposed, and were approximately four inches long. The support brackets created a potential injury risk for residents and staff. The risk factors associated with removing the foot boards were not considered.

B) Many falls arrest gel mats were observed to be on the floor, next to resident beds throughout the days on identified date in December 2017. The residents were not in bed at the time of the observations. According to the Director of Care, the mats were to be applied only when residents who required them were in bed, to prevent injury if they happened to fall out of bed. The mats were to be folded or rolled up and put away once the resident was out of bed. The mats were difficult to walk on as beds were checked during the inspection. PSWs reported that residents had difficulty walking over the mats to get to their beds and that staff had tripped over them in the past. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home is a safe environment for its residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

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

Findings/Faits saillants :

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

i. Resident #008 was identified as being usually continent of bowel on Minimum Data Set (MDS) coding completed on an identified dates in May 2017, August 2017 and November 2017; however the current plan of care identified bowel incontinence as a care focus. The resident's plan of care indicated the resident was

usually continent of bowel, but can be incontinent at times. Care interventions were established for this resident and documented in the plan of care. RN #101 confirmed that there were no other directions in the plan of care that provided directions to staff related to a toileting schedule. RN #101 confirmed that resident #008's plan of care did not provide clear directions to staff related to the resident's routine patterns or the process and timing for assisting the resident to the toilet.
ii. Resident #009's written plan of care did not set out clear directions for staff and others who provided direct care related to assisting the resident to the toilet. MDS coding completed on identified dates in June and September 2017 indicated the resident was incontinent. The current plan of care indicated that toileting was a care focus and a care interventions were in place, however, RN #101 confirmed that the written plan of care did not provide clear directions to staff related to how the resident was assisted to the toilet or what specific roles the staff were to play in assisting the resident to the toilet. [s. 6. (1) (c)]

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other as well as in the development and implementation of the plan of care so the different aspects of care were integrated and consistent with and complemented each other.

Nursing staff and the Physiotherapist did not collaborate with each other in the assessment of resident #003 or in the development and implementation of the plan of care for the resident related to the risk for falling.

i) The Physiotherapist completed a post fall referral on an identified date in 2017 and the responses documented on that date. During an interview on an identified date in 2017 the Physiotherapist confirmed they did not collaborate with nursing in the assessment of the resident or review the resident's plan of care before documenting the above noted directions.
The resident's plan of care related to falling included a goal that the resident would have no falls in the future. The Physiotherapist confirmed that they did not collaborate with nursing in the development of the plan of care when following referrals completed by the Physiotherapist they directed that physiotherapy and nursing interventions were to continue, there were no new care interventions added to resident #003's plan of care and the resident continued to fall.
ii) The physiotherapist completed a referral on an identified date in 2017 and following this assessment the referral response details directed the resident

required specific interventions. RPN #119 and the Physiotherapist confirmed they did not collaborate in the assessment and the development of the plan of care during or following the above noted referral, when interventions in the resident's plan of care indicated the resident required extensive a specific level of assistance and directions made by the Physiotherapist had not been included in the plan of care for resident #003.
Nursing and Physiotherapy did not collaborated in the assessment of resident #003 or in the development and implementation of the plan of care related to the risk of falling and resident #003 continued to experience falls. [s. 6. (4)]

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

i. On an identified date in 2017, resident #001 was receiving care by PSW #105. The PSW turned away from the resident and had their back to the resident, when the PSW returned the resident had fallen to the floor sustaining two superficial injuries. The care plan indicated that the resident when left unattended was to have specific interventions in place. PSW #105 confirmed they did not put the specific interventions in place prior to leaving the resident unattended and therefore the plan of care for the resident was not followed.
ii. On an identified date in 2016, RPN #125 observed PSW #126 mid way through a one person transfer with resident #019 who was being transferred. An interview with RPN #125 on an identified date in December 2017, confirmed that the PSW was struggling with the transfer and saw the staff member push the resident on the bed so the resident did not fall. RPN #125 confirmed the resident was a two person transfer for all transfers and the PSW did not follow resident #019's plan of care for transferring.
iii. On an identified date in 2016, during morning care PSW #121 transferred resident #018 by themselves and the resident needed to be lowered to the floor. In an interview with PSW #121 on an identified date in 2017, confirmed the resident was to be transferred using two staff members at all times and confirmed that they did not follow the resident's plan of care. [s. 6. (7)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed.

i. Resident #009's plan of care was not reviewed or revised when the resident care needs changed in relation to the resident's ability to use the toilet. At the time of

this inspection resident #009's plan of care included a care focus related to toilet use and the interventions for toileting. During a review of the resident's plan of care with RN #101 they confirmed that the resident no longer used those interventions for toileting. RN #101 confirmed that resident #009's plan of care was not reviewed or revised.
ii. Resident #023 was not reassessed and the plan of care was not reviewed or revised when the resident demonstrated a change in cognitive status in 2016. RPN #119 and clinical documentation confirmed that resident #023 was displaying increased cognitive changes and the resident was displaying unusual behaviours. RPN #119 and clinical documentation confirmed that at the time of this inspection there was no evidence in the clinical record that the change in resident #023's cognition had been reassessed and there were no care interventions in the plan of care to direct staff in the care to be provided to resident #023 related to the change in cognition.
iii. Resident #022's plan of care was not reviewed and revised following an incident on an identified date in 2016, when resident #022 physically abused a co-resident when the co-resident participated in a specified task which resident #022 did not like. Following the above noted incident staff submitted a referral to an outside behaviour support organization. The DOC and the clinical record confirmed that resident #022's plan of care had not been reviewed or revised in relation to the aggressive behaviour the resident demonstrated towards a co-resident at any time following the incident on the above noted date and up until the resident was discharged. [s. 6. (10) (b)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan had not been effective.

i. Resident #005 was not reassessed and the plan of care was not reviewed and revised when the plan of care related to incontinence had not been effective. Minimum Data Set (MDS) coding completed on identified dates in 2017, and RN #101 confirmed that the resident was incontinent. Resident #005's plan of care documented that the goal of care related to incontinence was that the resident would experience no more than a specified number of incontinent episodes. Clinical documentation made by Personal Support Workers (PSW) indicated the resident experienced incidents of incontinence on an identified dates in November and December 2017. RN #101 confirmed that the care provided to resident #005 had not been effective in achieving the identified goal of care, the resident had not been reassess and the plan of care had not been reviewed or revised when the

care provided was not effective in reaching the goal of care for this resident.
ii. Resident #003's plan of care was not reviewed or revised related to falling. The goal of care established for the resident was that the resident would experience no falls in the future. This goal of care was initiated on an identified date in early 2017 and had not been altered at any time prior to this inspection. RPN #119 confirmed that the resident's plan of care had not been reviewed or revised when no new care interventions had been initiated after the resident experienced multiple falls on identified dates in 2017 and the care provided to the resident had not been effective in achieving the identified goal of care. [s. 6. (10) (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 plan of care sets out clear directions to staff and staff collaborate with each other in their assessments so they are consistent and compliment each other, to ensure that the planned care for residents is provided and when the residents care needs change or the plan is not effective the plan of care is reviewed and revised, to be implemented voluntarily.

WN #8: 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 :

(A3)
1. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

In accordance with O. Reg. 79/10, s. 48(1) 3 the licensee is required to ensure there is a continence and bowel management program developed and implemented.
In accordance with O. Reg. 79/10, s. 30(1) the licensee shall ensure that each of the required programs under section 48 of this regulation have written policies, procedures and protocols.

The licensee's "Continence Management Program", identified as RC-14-01-01, last updated in February 2017 directed the nurse would "complete a Continence Assessment using a clinically appropriate assessment tool that is specifically designed for assessing continence. An assessment is completed with any deterioration in continence level".
Staff in the home failed to comply with the direction contained in the above noted policy when RN #101 and clinical documentation confirmed resident #005's continence had deteriorated in 2017. Clinical documentation indicated the resident experienced an increase in episodes of incontinence. RPN #109 confirmed that the resident was not assessed when clinical documentation indicated the resident's continence had deteriorated during the above noted period of time. [s. 8. (1) (b)]

2. The licensee failed to ensure that where the Act or this Regulation requires the

licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

In accordance with O. Reg. 79/10, s, 48(1) 2 the licensee is required to develop and implement a skin and wound care program.
In accordance with O. Reg. 79/10, s, 30 (1) 1 the licensee is required to have written policies, procedures and protocols for the interdisciplinary programs required under section 48 of the Regulations.
The licensee failed to ensure staff complied with the licensee's procedure identified in the "Skin and Wound Program: Wound Care Management" identified as RC-23-01-02 and last updated in February 2017. The above noted document included a procedure for the assessment of residents who exhibit altered skin integrity and directed staff to monitor the resident's skin condition with each dressing change and reassess at least weekly.
The DOC and RPN #119 confirmed that weekly skin assessments for resident's who demonstrate altered skin integrity were completed in the computerized clinical record. RPN #119 confirmed that resident #003 had altered skin integrity. The DOC, RPN #119 and the clinical record confirmed that weekly skin assessments were not completed for resident #003 on identified dates over a three month period in 2017 . [s. 8. (1) (b)]

3. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 1 the licensee is required to develop and implement a falls prevention and management program to reduce the incidents of falls and the risk of injury.
In accordance with O. Reg. 79/10, s. 30 (1) for each of the required interdisciplinary programs required under section 48 of the Regulation, there must be written policies, procedures and protocols.
The licensee's Falls Prevention and Management Program identified as RC-15-10-01 last updated in February 2017 directed that:
i) Following a fall, staff are to update the interdisciplinary care plan in collaboration with the resident and family/Substitute Decision Maker (SDM), obtain consent for

changes and communicate the care plan to all staff.
The licensee failed to ensure staff complied with these directions with respect to the multiple falls resident #003 experienced over a two month period in 2017. RPN #119 and clinical documentation confirmed that no updates were made to the resident's plan of care.
ii) The Falling Star/Leaf Flagging Guide identified as Appendix 7 in the licensee's Falls Prevention and Management Program directed that residents with a falls risk screen greater that seven will be flagged. Post-Fall Assessments completed for resident #003 with regard to the multiple falls they experienced over a two month period in 2017 identified the resident's fall risk. RPN #119 confirmed that staff place a logo on the name plate for any resident who was identified as having an identified risk for falling, which this resident had. RPN #119 and observations made at the time of this inspection confirmed staff did not comply with this direction when there was no flag to identify that resident #003 was at an identified risk for falling. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home's policies are followed, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were protected from abuse by anyone.

In accordance with the Long-Term Care Homes Act, 2007, Ontario Regulation 79/10, s. 2 (1) financial abuse is defined as: any misappropriation or misuse of a resident's money or property.

On an identified date in 2017, resident #015's SDM brought them in a gift with an identified value. On an identified date later than a month, the gift was noted to be missing. The home conducted an investigation and on an identified date the following month, the police retrieved a photo of the person in possession of the gift and the former DOC confirmed to the police that it was an identified employee who worked at the home. The licensee failed to ensure that resident #015 was protected from financial abuse. [s. 19. (1)]

2. The licensee failed to ensure resident #023 was protected from physical abuse by resident #022.
In accordance with O. Reg. 79/10, s. 2 (1) physical abuse is defined as the use of physical force by a resident that causes physical injury to another resident.

Resident #023 was physically abused by resident #022 on an identified date in 2016. Registered Practical Nurse (RPN) #119, clinical documentation and information provided to the Ministry of Health and Long Term Care (MOHLTC) confirmed that on that staff found resident #022 physically assaulting resident #023 . As a result of this incident resident #023 sustained several injuries. RPN #119 and clinical documentation confirmed that resident #023 had become increasing confused prior to the incident identified above; however the resident was not assessed when it was noted that their condition had changed and there were no care interventions identified to manage this change in the resident's condition.

The licensee failed to protect resident #023 from abuse by co-resident #022. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents are protected from abuse, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with related to s.20 (2) d, the duty under section 24 to make mandatory reports.
i. The home's policy that was in place at the time of an incident of abuse [Zero Tolerance of Resident Abuse and Neglect Response and Reporting" (RC-02-01-02; last revised April, 2017] directed staff to immediately advise the home of any suspected abuse of a resident.
ii. A Critical Incident System report was submitted to the Director four days after it was reported to the home regarding the alleged allegation of abuse took place. A review of the home's notes identified that the resident reported the alleged incident of abuse on an identified date in 2017. In an interview on an identified date in 2017, with RN #116, confirmed that they did not follow the home's abuse policy and immediately report to the Manager on call that the suspected abuse took place but left a note for the DOC. [s. 20. (1)]

2. The licensee failed to ensure that staff complied with the licensee's policy to promote zero tolerance of abuse and neglect of residents.
Licensee's policy "Zero Tolerance of Resident Abuse and Neglect", identified as RC-02-01-01 and last reviewed in April 2017, directed that:
"Staff would identify and correct situations where abuse, neglect and/or mistreatment can occur" and at a minimum:
-"Assess resident capacity on a regular basis, especially if there are significant changes in the resident's condition".
-"Develop a comprehensive care plan on admission, readmission and at minimum quarterly thereafter, for residents with needs and behaviours that may lead to altercations, victimization or aggression and ensure all caregivers are aware of and compliant with its contents".

i. The licensee failed to ensure that staff complied with the directions noted above when staff did not reassess resident #023 when RPN #119 and clinical documentation confirmed that the resident was demonstrating an increased significant change over two months in 2016. RPN #119 and clinical documentation confirmed that staff did not assess resident #023 when the resident's condition changed.
ii. The licensee failed to ensure that staff complied with the directions noted above when staff did not develop a comprehensive care plan at minimum quarterly, for resident #022 when staff became aware that the resident demonstrated a behaviour that lead to a physical altercation with resident #023. Following an incident that occurred on an identified date in 2016, when resident #022 physically assaulted resident #023. The DOC confirmed that staff had not developed a care plan related to the management of resident #022's behaviour that lead to an altercation with a co-resident and there were no care interventions put in place to prevent a reoccurrence of resident #022's aggressive behaviour towards other co-residents. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home follows their abuse policy, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
6. Psychological well-being. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
11. Seasonal risk relating to hot weather. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's plan of care was based on, at a minimum, interdisciplinary assessment of the resident's physiological well-being.

Resident #002 and clinical documentation confirmed that the resident's physicians had diagnosed the resident with a specific diagnosis. Resident #002 and the clinical record confirmed that the resident experienced what had been described as symptoms of the diagnosis. During an interview the resident described the symptoms as having a negative impact on their daily activities and that staff did not demonstrate an understanding of their care needs related to the diagnosis.
The DOC, RPN #108 and the clinical record confirmed that there were no care directions for staff who provided care to the resident in relation to actions to take when the resident experienced symptoms of the diagnosis and the only intervention identified in the plan of care was to provide medications as ordered.
RPN #108 confirmed that the resident's plan of care was not based on an interdisciplinary assessment of the resident's symptoms as there had not been an interdisciplinary assessment completed related to the symptoms the resident demonstrated associated with the above noted diagnosis. [s. 26. (3) 6.]

2. The licensee failed to ensure that a plan of care was not based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Seasonal risk relating to hot weather.

Residents #002, 005, 012, 040, 041, 042 and 043 did not have written plans of care related to their health risks related to hot weather. Each residents' clinical records were reviewed and three residents were assessed to be at a certain risk level for heat related symptoms and resident #040 did not have a heat risk assessment for 2017. According to an RN of the home, a heat risk assessment was required to be completed upon admission and yearly (before the summer season) for each resident and the outcome of their risk, along with interventions documented in their written plan of care.

During the month of September 2017, four days exceeded a Humidex of 31 (a combination of humidity and air temperature). A Humidex of 39 was recorded by Environment Canada on September 23 and 24, 2017. The Ministry of Health and Long Term Care received a complaint at the time identifying that residents were feeling ill and not coping well because of the excessive air temperatures in the home. [s. 26. (3) 11.]

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 residents plan of care are based on an interdisciplinary assessment of their physiological well-being and hot weather related illness, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the requirements of this Regulation were complied with related to the Continence Care and Bowel Management Program.
In accordance with O. Reg. s, 48(1) 3 the licensee is required to ensure an interdisciplinary program of Continence Care and Bowel Management is to be developed and implemented in the home.
i. The licensee failed to comply with O. Reg, s. 30 (1) 1, when they failed to ensure that the written description of the Continence Care and Bowel Management Program included program goals and objectives.
The Administrator provided a document "Continence Management Program", identified as RC-14-01-01 that was last updated in February 2017. The Administrator confirmed that this document did not contain program goals and objectives. At the time of this inspection the Administrator reviewed other documents available related to continence care, in the presence of this Inspector

and confirmed that none of the documents reviewed contained program goals and objectives. RPN #108 who held the position as Quality Coordinator confirmed they were unaware of the goals and objectives of the continence and bowel care program. At the time of this inspection there were no goals and objectives identified for the Continence Care and Bowel Management program.
ii. The licensee failed to comply with O. Reg, s. 30 (1) 3 when they failed to ensure that the Continence Care and Bowel Management Program was evaluated for the 2016 calendar year when they did not evaluate the Bowel Management Program in the home. The Administrator provided a document identified as "Quality Program Evaluation – Continence Care and Bowel Management", which was signed by the Administrator and the Director of Care on an identified date in July 2016. The document provided information related to the percentage of residents with worsening bladder continence and the resident continence survey, but did not provide any information in relation to an evaluation of the bowel management over the period of the evaluation.
iii. The licensee failed to comply with O. Reg, s. 30 (1) 4, when they failed to keep a written record of actions taken when the above noted document indicated that during a staff survey it was identified that staff sometimes run out of incontinent products and there were no actions identified to address the issue staff raised related to the shortage of incontinent products. [s. 30. (1)]

2. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 4. The licensee did not keep a written record relating to each evaluation under paragraph 3 that included 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.

i. A review was completed of the skin and wound care program evaluation. It was identified that the evaluations did not identify the dates that any changes were implemented. This was confirmed with the Administrator during an interview on an identified date in December 2017.
ii. A review was completed of the Falls prevention program evaluation. It was identified that the evaluations did not identify the dates that any changes were implemented. This was confirmed with the Administrator during an interview on an identified date in December 2017. [s. 30. (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 goals and objectives are part of programs and that the dates of changes in the programs are documented, to be implemented voluntarily.

WN #13: 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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of registered nursing staff.

Resident #007 had a diagnosis for a chronic skin condition The resident was admitted to the home on an identified date in 2017 and a skin assessment was completed at this time. A review of the resident's clinical record confirmed that only one weekly wound assessment was completed on an identified date in 2017, other than the admission assessment. In an interview with RPN #113 they confirmed that weekly skin and wound assessments should have been completed for this resident. [s. 50. (2) (b) (iv)]

2. The licensee failed 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 appropriate.

Staff did not complete weekly reassessments of resident #003 when it was identified the resident had altered skin integrity affecting an identified areas and the resident's physician ordered daily treatments. RPN #119, the DOC and the clinical record confirmed that weekly skin assessments were completed in the computerized clinical record and skin assessment were not completed on identified dates over a three month period in 2017.
The DOC, RPN #119 and the clinical record confirmed that weekly skin assessments were not completed for resident #003 when it was identified that the resident had wounds.
[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 residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of registered nursing staff, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

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

i. Resident #005 was identified as experiencing incontinence when MDS coding completed on identified dates in 2017 indicated the resident was incontinent. Registered Nurse (RN) #101 confirmed resident #005 was incontinent. RPN #109 confirmed that there was no evidence in resident #005's clinical record that would indicate the resident was assessed in accordance with this requirement.
Resident #005 did not receive an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence when the resident was identified as being incontinent.
ii. Resident #008 was identified as being incontinent when MDS coding completed on identified dates in 2017, indicated the resident was usually continent of bowel and frequently incontinent of bladder. RN #101 confirmed resident #005 was incontinent. RPN #109 confirmed that there was no evidence in resident #008's clinical record that would indicate the resident was assessed in accordance with this requirement.
Resident #008 did not receive an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence when the resident was identified as being incontinent. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that criminal reference checks are conducted prior to hiring the staff member.

A review of PSW #133's employee file with the Administrator on an identified date in December 2017, confirmed that the licensee was unable to provide evidence that a criminal reference check was completed prior to hiring PSW #133 who was greater than 18 years of age. [s. 75. (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 criminal reference checks are conducted prior to hiring all staff members, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff at the home received training as required by this section.

The licensee failed to ensure that no person mentioned in the Long Term Care Homes Act 2017, c. 8, s. 76(1) performed their responsibility before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76 (2).

The licensee failed to ensure that all staff at the home received training in other areas provided for in the regulations, specifically in accordance with O. Reg. 79/10, s. 221(1) 3, in the area of Continence Care and Bowel Management.

In accordance with O. Reg. 79/10, s 221(1) 3 the licensee is required to provide training to all staff who provide direct care to residents in the area of Continence Care and Bowel Management.

In accordance with O. Reg. 79/10, s. 219 (1) the training intervals for the purposes of subsection 76(4) of the Act are annual intervals.

The Administrator confirmed that at the time of this inspection they were not able to provide documentation to demonstrate that staffs' learning needs had been assessed in 2016. The Administrator provided documentation of training provided to staff who provided direct care to residents in 2016 and it was confirmed that 24 of 88 (27%) staff had not received training in the above noted area in the 2016

calendar year. [s. 76. (2)]

2. The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training the areas set out in the following paragraphs, at times or at intervals provided for in the regulation: 1. Abuse recognition and prevention.

According to the Regulations under section 221, subsection 2 (1), the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.

A review of the home's abuse training identified that not all direct care staff completed the mandatory abuse training. The Administrator confirmed that only 96.4 percent (%) of staff completed mandatory annual abuse training in 2016. [s. 76. (7) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home conducts the required training for abuse and continence care, to be implemented voluntarily.

WN #17: 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. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker, if any, and the resident's physician/prescriber of the drug.

The DOC confirmed that if the required notification of a medication incident

involving a resident was not documented on the Medication Incident Report (MIR) or in the resident's clinical record that the notification had not occurred.

i. Resident #013 had a designated SDM for both personal care and finances. On an identified date in 2017, staff documented on a MIR that the resident received an extra dose of medication. The MIR provided an opportunity for staff to document if they had notified the resident and/or the SDM. Documentation on the MIR indicated that none of the above noted individuals had been notified of this medication incident. A review of the resident's clinical record confirmed that there was no documentation on the date of the medication incident or following the medication incident that any of the above noted individuals had been notified of the medication incident.
ii. Resident #015 was their own SDM. On an identified date in 2017, staff documented on a MIR that the resident did not receive their medication as ordered. The MIR provided an opportunity for staff to document if they had notified the resident's physician. Documentation on the MIR indicated that none of the above noted individuals had been notified of this medication incident. A review of the resident's clinical record confirmed that there was no documentation on the date of the medication incident or following the medication incident that any of the above noted individuals had been notified of the medication incident.
The licensee failed to notify resident #013's SDM that a medication incident had occurred and the licensee failed to also notify resident #017's physician that the medication incident had occurred. In an interview with the Pharmacist for the home on an identified date in 2017, confirmed that the pharmacy was also not made aware of the above medication incidents as the licensee only sent incidents that were made by the pharmacy and not all medication incidents. [s. 135. (1)]

2. The licensee failed to ensure that all medication incidents and adverse drug reactions were reviewed, analyzed and corrective action was taken as necessary.

i) The home provided a MIR that indicated resident #013 had received an extra dose of their medication on an identified date in 2017. A review of the MIR confirmed that there was not a review of the incident or the circumstances that lead to the incident. The Administrator confirmed there was no other documentation related to this medication incident at the time of this inspection.
ii) The home provided a MIR that indicated resident #015 had not received their medication as prescribed by the resident's Physician on an identified date in 2017. A review of the MIR confirmed that there was not a review of the incident or the circumstances that lead to the incident nor was the incident analyzed to determine

what if any corrective action might be appropriate to prevent a recurrence. The Administrator confirmed there was no other documentation related to this medication incident at the time of this inspection. [s. 135. (2)]

3. The licensee failed to ensure that a written record was kept of the quarterly medication incident review.

The Administrator confirmed that the quarterly review of medication incidents would occur during the Professional Advisory Committee (PAC) meetings that were held on a quarterly basis. Minutes of the PAC meeting held on an identified date in June, 2017, were provided. A review of the minutes of this meeting confirmed that there were no minutes recorded that would indicate the medication incidents over the last three months had been reviewed at the meeting. A chart that gave a brief outline of the medication incidents that occurred between April and June 2017 was included with the minutes provided. The chart indicated there were five medication incidents during the above noted period of time and all of the incidents resulted in residents not receiving the medication as was specified in the Physician's orders. The Administrator confirmed that there was no other documentation related to the review of medication incidents during the period of the review. [s. 135. (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 o 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, and the resident's physician/prescriber of the drug and to ensure that all medication incidents and adverse drug reactions were reviewed, analyzed and corrective action was taken as necessary and a written record is kept, to be implemented voluntarily.

WN #18: 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. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that the information gathered under subsection (5) was analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends for the purpose of reducing the incidence of infection and outbreaks.

During an identified month in 2017, daily surveillance sheets for resident symptoms revealed that one resident had a cough on an identified date that month in 2017, and one had a sore throat on an identified date that month in 2017. On an identified date in 2017, a total of four residents had coughs, congestion and sore throat. Four new cases appeared on an identified date that month 2017. A RN confirmed that they were aware of all of the residents who presented with the symptoms and stated that each were seen by a physician. This was verified by reviewing the clinical records for the affected residents. The majority of residents received medication for their respiratory symptoms. The RN reported they did not analyze the data on a daily basis, as the surveillance sheets were provided to the DOC. The DOC, was not interviewed and could not verify why their local public health unit was not contacted to report an outbreak.
According to prevailing practices titled "Surveillance of health care-associated infections in patient and resident populations, October, 2011", developed by the Provincial Diseases Advisory Committee, residents presenting with two or more symptoms related to the common cold syndrome of runny nose, dry cough, sneezing, stuffy nose (congestion) or sore throat would qualify as having an infection. As such, if the data was analyzed daily, as required, the presence of infection in the home should have been detected and an outbreak reported when there were two or more residents presenting with the same set of symptoms. In this case, a trend was not identified for the purpose of reducing the incidence of an outbreak. [s. 229. (6)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all data is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 22. Every licensee of a long-term care home shall ensure that all plumbing fixtures in the home with hose attachments are equipped with a back flow device. O. Reg. 79/10, s. 22.

Findings/Faits saillants :

1. The licensee of a long-term care home failed to ensure that all plumbing fixtures in the home with hose attachments were equipped with a back flow device.

A section of green garden hose was observed to be connected to a short faucet of the three compartment sink located in the dish wash area of the main kitchen. The hose was long enough to sit inside the centre sink. When the hose was tested, it appeared that it was attached to allow staff to have access to a sink on either side of the centre sink, either to fill the sinks or rinse items with it. The faucet was not equipped with a back flow device to prevent dish water from being sucked up into the hose and back into the potable water supply line. [s. 22.]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following:

s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that immediate action was taken to deal with pests.

On an identified date in December 2017, a cloud of black eyed fruit flies (which are larger and darker than fruit flies commonly seen around fruit) was observed in the main kitchen dish wash area, near the large garbage. The flies had spread throughout the building as they were noted in the hair salon and on the other floors of the home in resident rooms. The licensee had a contract with a company to visit the home on a monthly basis to check pest activity. The last visit was made in December 2017, with no findings. Bottle or flesh files were identified by the pest control technician in August 2017, and new glue boards added to the light traps, however no fruit flies were included in the findings. Dark eyed fruit flies lay eggs and breed in wet damp areas, including floor drains, under cracked or broken floor tiles, inside wet wall board material or inside the hollow legs of tables and other fixed equipment. They are not attracted to any light traps and are more difficult to eradicate. Their control depends on managing these breeding sites with good general sanitation, various foam products provided by pest control companies and ensuring that floors, drains and wall materials are in good condition. Based on the poor sanitary conditions noted in the dish wash area of the kitchen on an identified date in December 2017, and the lack of monitoring of the flies, the licensee did not take immediate action to deal with the flies. [s. 88. (2)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead — housekeeping, laundry, maintenance

Specifically failed to comply with the following:

s. 92. (2) The designated lead must have,
(a) a post-secondary degree or diploma; O. Reg. 79/10, s. 92 (2).
(b) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and O. Reg. 79/10, s. 92 (2).
(c) a minimum of two years experience in a managerial or supervisory capacity. O. Reg. 79/10, s. 92 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the designated lead for the housekeeping, laundry and maintenance services programs had knowledge of prevailing practices relating to housekeeping, laundry and maintenance.

A new manager for each of the above noted service programs was hired by the licensee within the last three months. The manager confirmed that they also managed the food services program and had a post-secondary diploma in food services. The manager was not able to establish what knowledge (facts, information, and skills) they had acquired either through experience or education with respect to housekeeping, laundry or maintenance. They were not aware of the various prevailing practices associated with housekeeping, laundry or maintenance. The prevailing practices applies to what is most frequent or common at a certain time or in a certain place. In Ontario, the prevailing practices for housekeeping, maintenance and laundry include numerous associations and organizations that have developed generally-accepted, informally-standardized techniques, methods or processes that have proven themselves over time to accomplish given tasks. They include but are not limited to The Ontario Healthcare Housekeepers Association, Public Health Ontario, Health Canada, Ontario Building Code, Electrical Standards Authority, Heating, Refrigeration and Air Conditioning Institute of Canada, Technical Standards and Safety Authority and many others. [s. 92. (2)]

WN #22: 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):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. 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): 3. A missing or unaccounted for controlled substance.

A review of the home's medication incident reports, confirmed that the home had a missing controlled substance. The incident report confirmed that on an identified date in 2017, at shift count that a controlled substance was missing. An interview with the former DOC on an identified date in December 2017, confirmed that they did not inform the Director of the missing controlled substance. [s. 107. (3) 3.]

Issued on this 18 day of June 2018 (A4)

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

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by BERNADETTE SUSNIK (120) - (A4)

Inspection No. / No de l'inspection : 2017_555506_0027 (A4)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 027381-17 (A4)

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

Report Date(s) / Date(s) du Rapport : Jun 18, 2018;(A4)

Licensee / Titulaire de permis : Blackadar Continuing Care Centre Inc.
101 Creighton Road, DUNDAS, ON, L9H-3B7

LTC Home / Foyer de SLD : Blackadar Continuing Care Centre
101 Creighton Road, DUNDAS, ON, L9H-3B7

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Shelly Desgagne

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 Blackadar Continuing Care Centre Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 shall:

1. Review the home's access to Registered Nurses (RNs) that are an employee of the licensee and members of the regular nursing staff of the home to ensure there are enough RNs to meet the licensee's staffing needs and allow for absences such as illness and vacation coverage and implement recruitment strategies.
2. Ensure that a RN who is an employee of the home is scheduled to work in the home and on duty and present at all times except as provided for in the regulations.

Grounds / Motifs :

1. This order is based on the application of the factors of severity (2), scope (1) and compliance history (4) in keeping with O. Reg 79/10, s. 299. This is in respect to the severity of potential of harm for residents, the scope of isolated and the licensee's history of non-compliance that included: voluntary plans of corrective action (VPC) issued in February 2016 and a written notice (WN) in January 2015.

A. Blackadar is a long term care home with a licensed capacity of 80 beds. The planned staffing pattern for registered nursing staff in the home, for the direct care of

residents, was three RNs for a total of 24 hours a day, as identified on work schedules provided by the home and confirmed by the Administrator.
During an interview on an identified date in December 2017, with the Administrator and the Nursing Clerk identified that, the home did not have a sufficient number of RNs within the staffing plan to fill all the shifts related to staffing events such as sick calls. The Administrator and the Nursing Clerk confirmed that the home consistently offered additional shifts to regular registered nurses to fill these vacant shifts; however, when the registered nurses employed by the home were unwilling or unable to work one or more of the required shifts the home would fill those shifts with registered nurses employed with an employment agency. On request the home provided a list of shifts from December 2016, until November 2017, which identified there were 37 occasions where agency registered nurses worked to ensure that a registered nurse was on site 24 hours a day. The Administrator and Nursing Clerk confirmed that the need to fill these RN shifts were not the result of emergency situations as outlined in O. Reg 79/10, s. 45(2).
The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times.
B. Review of the home's schedules from December, 2016, until November 2017, identified that there were dates when there was no RN in the building and the home used an employment agency to replace the RN with a registered practical nurse (RPN) or one of the home's RPN's.
i.On an identified date in January 2017, the home used an agency RPN for the evening shift.
ii.On an identified date in January 2017, the home used an RPN that worked at the home for the day shift.
iii.On an identified date in January 2017, from 1930 hours until 2245 hours there was no RN in the home.
iv.On an identified date in April 2017, the home used an agency RPN for the night shift.
v.On an identified date in June 2017, the home used an agency RPN for the night shift.
vi.On an identified date in July 2017, the home used an agency RPN for the evening shift.
vii.On an identified date in September 2017, from 1545 hours until 1900 hours there was no RN in the home.
The Administrator and the Nursing Clerk confirmed that the employment agency did not have an RN available to replace the RN shifts and therefore used an agency

RPN or an RPN that worked at the home to cover the shifts.
The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times.

(506)

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

Apr 20, 2018

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

(A1)
1. The licensee will ensure that staff use safe transferring and positioning devices or techniques when assisting residents.
2. The licensee will provide education and training to all staff involved in the transfer and positioning of residents. Attendance records are to be maintained
related to this training.
3. The licensee will develop and implement a system for monitoring staff's performance in complying with directions identified in residents plans of care for
transferring and positioning.

Grounds / Motifs :

1. This order is based on the application of the factors of severity (3), scope (2) and compliance history (4) in keeping with O. Reg 79/10, s. 299. This is in respect to the severity of actual harm for the identified residents, the scope of pattern and the licensee's history of non-compliance that included: voluntary plans of corrective action (VPC) issued in January 2015.

The licensee failed to ensure that residents were transferred using safe transferring and positioning techniques.

i. On an identified date in 2016, resident #018 was in the room with PSW #124 and the resident slid down to the floor. An interview with PSW #124 confirmed that they were assisting the resident by themselves and another PSW was outside the room. A review of the care plan and interview with the Quality Co-ordinator nurse confirmed the resident was always a two person transfer.
ii. On an identified date in 2016, resident #018 was complaining of pain to an identified area. PSW #121 in an interview confirmed that during morning care resident #018 was transferred by one staff to their medical device and the resident was not weight bearing well and needed to be lowered to the ground. PSW #121 confirmed with the Long Term Care (LTC) Inspector on an identified date in 2017, that the resident was a two person transfer but they transferred the resident by themselves. PSW #121 confirmed as well that when the resident was lowered to the ground the PSW did not go and get the registered staff to assess the resident immediately for any injuries as the registered staff was busy at the time. The

registered staff was not made aware of what happened until the resident was found in pain. At this time the resident was sent to the hospital for assessment and it was confirmed that the resident sustained an injury. In an interview with the former DOC of the home on an identified date in 2017, confirmed that the resident was not transferred using safe transferring techniques.

iii. PSW #126 did not use safe transferring and positioning techniques while transferring resident #019. On an identified date in 2016, RPN #125 observed PSW #126 transferring resident #019 by themselves. The resident's plan of care indicated that the resident was a two person transfer. The RPN confirmed in an interview on an identified date in 2017, that the PSW was struggling with the transfer as the resident was not pivoting and unsteady on their feet and the resident was falling towards them and the PSW had to push the resident firmly so they would not fall. The RPN confirmed that the PSW did not use safe transferring and positioning techniques while transferring the resident.

iv. On an identified date in 2017, resident #001 was receiving care by PSW #105. The PSW turned away from the resident and had their back to the resident, when the PSW returned the resident had fallen to the floor sustaining superficial injuries to two identified areas. The care plan indicated that the resident when left unattended was to have specific interventions in place. The interim DOC at the time of this inspection confirmed on an identified date in 2017, that the resident was not left in a safe position as the specific interventions were not put in place.

(506)

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

Apr 20, 2018

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall complete the following:
1. Repair the terrazzo flooring material in the two shower areas and the dish wash area of the kitchen so that the floor is smooth, sealed and easy to clean. The flooring material shall be re-surfaced by April 27, 2018.
2. Replace the disinfectant hose on the tub located on the third floor and ensure the disinfectant can be diluted and dispensed through the hose as required by the manufacturer.
3. A general preventive maintenance or condition audit shall be conducted of every resident occupied space within the building that includes who did the audit, what was checked, the date it was checked, the follow up action taken, date of follow up action and who completed the follow up action. The audit shall be completed by June 15, 2018 and available for review by the inspector.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. This order is based on the application of the factors of severity (2), scope (3) and compliance history (4) in keeping with O. Reg 79/10, s. 299. This is in respect to the severity of minimal harm or potential of harm, the scope of widespread and the licensee's history of non-compliance that included: voluntary plans of corrective action (VPC) issued in 2016 and a WN under s. 90 similar area in 2014.

As part of the organized program of maintenance services under clause 15(1)(C) of the Act, the licensee did not ensure that the home, furnishings and equipment were maintained in a good state of repair.

1. The terrazzo flooring material (made of chips of marble, quartz or granite poured with a cementitious binder) in the kitchen dish wash area and in both shower areas was in poor condition. The cementitious binder had eroded, with chips of rock exposed and the surface rough. Evidence of previous filler was noted where repairs were attempted in the past. The flooring material could not be cleaned or disinfected and water was observed pooling in the hundreds of crevices.
2. The bath tub located on an identified unit was observed to have a missing spray nozzle for the disinfectant hose attached. According to PSWs, the nozzle had been missing for over four years. According to the ESS, a company was hired to inspect the bath tubs, but did not identify the disrepair.
3. Bathroom sink faucets were corroded in identified rooms, a rusty sink drain was observed in an identified room, rusty grab bars were observed in two identified areas, a rusty base was observed on an over bed table in an identified room and a damaged foot board was noted on a bed in an identified room.
(120)

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

Jun 15, 2018

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall complete the following:

1. Amend the home's existing " Bed Rail Entrapment and Risk Assessment " form related to resident clinical assessments and the use of bed rails to include additional relevant questions and guidance related to bed safety hazards related to:
a) the resident while sleeping for a specified period of time in their bed system with one or more bed rails applied, that establishes their ability to understand and independently use their bed rail(s) or any other accessory or bed component that has been deemed necessary; and
b) whether the resident displayed any sleep related behaviours that could have increased their chances of becoming injured, suspended, entangled or entrapped, and
c) whether the alternatives that were trialled prior to using one or more bed rails were effective or not during a specified period and document the outcome.

2. Develop or acquire fact sheets or pamphlets that can be made available

for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario. The hand out or fact sheet shall include information regarding the assessment process of residents once admitted to the home related to bed rail use, the risk factors that are considered high risk for bed system injury, suspension, entanglement or entrapment, the benefits versus the risks of bed rail use, alternatives to bed rail use, the role of the Substitute Decision Maker and consents, how bed systems are monitored to ensure they do not pose a safety risk for residents, and the contact information for Health Canada, Medical Devices Bureau for additional information and any bed system related injury, entrapment, entanglement or suspension event.

3. Re-evaluate all beds to ensure that all mattresses are appropriately sized for the bed frame and are matched to the bed frame either by serial number or other unique identifier. If mattresses cannot be acquired to fit between the existing mattress keepers (for those beds with plastic keepers) or the mattress will not stay within the mattress keepers once placed, replace the plastic keepers with a different style of mattress keeper that will more easily accommodate the mattress.

4. Amend the current "Resident Bedrail Risk Assessment and Use" policy to include additional and relevant information noted in the prevailing practices identified as the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings", U.S. F.D.A, April 2003) and at a minimum the policy shall include;
a) details of the process of assessing residents upon admission and when a change in the resident's condition has been identified to monitor residents for risks associated with bed rail use and the use of any bed related attachments/accessories on an on-going basis; and
b) guidance for the assessors in being able to make clear decisions based on the data acquired by the various team members and to conclude and document the risk versus the benefits of the application of one or more bed rails for residents; and
c) alternatives that are available specifically for the replacement of bed rails and the process of trialling the alternatives and documenting their use; and
d) what interventions are available to mitigate any identified bed safety entrapment or injury risks should a resident benefit more from the use of one or more bed rail(s)(i.e. wedges, bolsters, bed rail pads) vs the risk; and

e) the role of the SDM and/or resident in selecting the appropriate device for bed mobility and transfers; and
f) the role of and responsibilities of personal support workers with respect to observing residents in bed related to their bed systems (which includes bed rails, bed frame, accessories, mattresses, bed remote controls) and associated safety hazards;
g) the various bed system malfunctions that need to be monitored for, by which staff members and how reported to maintenance for follow up.

5. Upon completion of the amendments to the assessment form and procedures, all direct care staff (RNs, RPNs, PSWs) shall receive face to face instruction. The training shall at a minimum include the following:
a) where the zones of entrapment are on each type of bed where there may be more than one style of bed rail applied; and
b) how a resident can become entrapped, entangled, suspended (depending on type of rail) and injured on the type of bed system they were provided; and
c) how to identify loose bed rails and ill-fitting mattresses and how to ensure mattresses remain in the bed keepers and who will be contacted when problems are identified; and
d) the contents of the procedures and associated forms shall be reviewed and a record shall be kept of those who participated and the dates attended.

6. Please reassess all residents who have bed rails in place including resident #005, #017, #044, #045 and #046.

Grounds / Motifs :

(A3)
1. This order is based on the application of the factors of severity (2), scope (3) and compliance history (4) in keeping with O. Reg 79/10, s. 299. This is in respect to the severity of minimal harm or potential for harm for the identified residents, the scope of widespread and the licensee's history of non-compliance that included: compliance orders (CO's) issued in March and July 2015.

The licensee did not ensure that where bed rails were used, residents were assessed in accordance with prevailing practices to minimize risk to the resident.

A companion guide titled "Clinical Guidance for the Assessment and Implementation

of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration) provides the necessary guidance in establishing a clinical assessment where bed rails are used. It is cited in a guidance document developed by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards, March 2008" and was identified by the Ministry of Health and Long Term Care in 2012, as the prevailing practice.

Five residents (#005, 017,044, 045 and 046) were randomly selected during this inspection to determine if they were assessed for bed related safety risks in accordance with the clinical guidelines. A registered nurse, confirmed that they had completed many of the assessments, including several that were reviewed. The assessment was determined to be missing several procedures in identifying the risk over the benefits of bed rail use for residents using one or more bed rails.

A) The licensee's policy and procedure titled "Bed Rail Minimization and Risk Reduction" (RC 08-01-09) dated April 2017, included direction that residents would be assessed by an interdisciplinary care team to determine the continued need for the bed rail on a quarterly basis (where bed rails were previously evaluated and the resident was previously assessed) and upon admission or change in condition. A form titled the "Bed Rail Entrapment and Risk Assessment (BRERA)" was to be completed by registered staff. The risk reduction policy also referred the reader to a secondary policy titled "Personal Assistance Services Devices (PASD)", which included bed rails, dated February 2017. It directed the interdisciplinary team to trial and document the use of alternatives before applying a PASD (bed rail). It further included the requirement to document the purpose and time frame for the use of the PASD in the resident's written plan of care.

No guidelines or details were included in the risk reduction policy as to how residents would be assessed for risk-related hazards once bed rails were applied. According to the Clinical Guidance document, once bed rails are applied, residents would need to be monitored for sleep patterns, behaviours and other factors while sleeping in bed over a period of time to establish risk-related hazards associated with their bed rails. The licensee's policy would need to establish who was to monitor the residents, for how long and what specific hazards would need to be monitored while the resident was in bed.

No guidelines or details were included in the PASD policy regarding what specific

alternatives to bed rails were available for staff to trial with the residents. The alternatives that were listed in the policy included "improved lighting, increased supervision, prompting during the completion of the activity of daily living (ADL), re-enforcement/teaching of technique/method of completing ADL, noise reduction, pain management and adaptive aides. No specific options were listed such as transfer pole, bed rail guards or padding, height adjustable bed, raised perimeter mattress (easier to grab than a flat mattress when being repositioned) or adjustable bolsters (also known as soft rails). Neither policy included what strategies, accessories or options were available to staff and the resident if certain bed safety risks were identified such as suspension, bruising, entanglement or entrapment (for the various different zones).

According to one RN and educator for the home, the process, once residents were newly admitted to the home, was to place the resident in bed without bed rails attached for the first several nights, to get an understanding of whether or not the resident could move about in bed independently and whether they could get in and out of bed independently. The PSWs and night shift RN were tasked at monitoring the residents. This included falls from bed, ability to use the nurse call system, whether they slept soundly or not and other conditions related to pain, comfort and toileting. If the interdisciplinary team all agreed that the resident would benefit from one or more bed rails, consent would be obtained from the family or resident and the bed rails applied. The RN (or other registered staff) gathered all of the information, including information gathered from the family from the admission process and completed the BRERA form. No risk assessment was formally conducted with residents after they received a bed rail and no documentation was made as to whether there were any bed related risk hazards. When PSWs were asked if they were oriented (actually shown) to the hazards of bed rail use, they replied that no hands on training was received and their knowledge related to bed entrapment was acquired from a computer training module. The PSWs did not have any guidance as to what they were to observe once bed rails were applied such as observing for body parts through the rail (zone 1), bruising or injury against the bed rail, ill-fitting mattresses, loose and ill-fitting bed rails, suspension around a bed rail (if centrally located on the bed) and whether the bed rail was used safely and appropriately.

B) Five out of the five clinical bed safety assessments that were completed within the last six months did not include what bed rail alternatives were trialled before the bed rails were applied. The BRERA form did not include an area for the assessor to complete related to alternatives trialled, when applied, for how long and whether

successful or not. The residents' clinical records (progress notes) were reviewed and did not include any reference to alternatives trialled.

C) The BRERA form that was used to complete the five resident assessments did not include any information about the residents while asleep after bed rails were applied. The form included three sections. Section A of the BRERA form included questions related to what conditions contributed to a resident's risk of entrapment such as history of bed related injury, communication issues, medical symptoms, history of falls out of bed, ability to self-ambulate, medication use, cognition level and understanding, if agitated, ability to ambulate to and from the bed, body size etc. An area was left open for the assessor to summarize the resident's individual risk for entrapment. Section B of the BRERA form included three questions related to the resident's independence in using the bed rail for positioning and whether they were at risk of entrapment. Section C of the BRERA form included a check list to ensure that the plan of care was updated, what was discussed (alternatives, risk and consent) and what bed rails (if any) the resident would use while in bed. The name of the assessor, names of staff who participated in the assessment, or dates were not listed on the form. For these details, other areas of the resident's electronic record needed to be explored.

D) Mattresses were observed to be ill-fitting on many bed frames located in resident rooms, with and without bed rails (in rooms #205, 212, 213, 214, 305, 315). Some of the bed systems were equipped with plastic mattress keepers on each corner of the bed to keep the mattress from sliding off the bed, especially where bed rails were not included. Various reasons were identified as to why these mattresses were found sitting on top of the keepers, either at the head of the bed, foot of the bed or on all four corners. Some mattresses, after the beds were made by staff, did not get pushed back into the keepers, others could only be pushed down into the keepers after the comforter or blanket was removed from the corners of the mattresses and other mattresses were too long to fit properly (#216). Mattress keepers were missing from beds in #215-3, 204, 216 (head end only) and 308 (head end only).

Potential entrapment hazards were identified with several beds with either missing mattress keepers or with mattresses sitting on top of the mattress keepers where bed rails were applied. Resident #044 had a quarter length bed rail elevated on their right side (resident was not in bed at the time). The mattress was not secured and was easily pushed askew. The action caused a gap to form in and around the bed rail. Resident #045 was in bed at the time of observation, with their mattress on top

of the mattress keepers at the foot end of the bed and their right side rotating assist rail in the transfer position. The formation of a gap was a concern if the resident shifted their mattress.

The risk factors associated with bed systems where bed rails were applied and had missing mattress keepers and where mattresses were secured to the bed frame were not considered and incorporated in the resident's clinical assessment (during a sleep observation period).

E) Loose bed rails were noted on several resident beds, creating a condition that could increase bed related injury or entrapment for the resident. For resident #017, who was in bed on December 14, 2017, both rotating assist bed rails were in the guard position. The bed rail on their left was quite loose, creating a large gap between the bedrail and the mattress (end of bed rail). For resident #005, who was not in bed at the time of observation on December 18, 2017, one rotating assist bed rail was in the guard position and was very loose, creating a gap. For resident #046, the resident was not in bed at the time of observation on December 14, 2017, however, their rotating assist bed rail was loose on the right side, which created a large gap between the mattress and bed rail. The loose bed rails were not reported to the registered staff or maintenance staff by either PSWs or housekeeping staff. A housekeeper and several PSWs who were asked if they were aware of the loose bed rails reported that they did not know about their condition and when shown, were not aware of how stiff or loose the bed rails should have been.

The licensee therefore did not assess residents in accordance with prevailing practices, to minimize risk to the resident. (120)

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

Aug 31, 2018

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

(a) cleaning of the home, including,

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

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

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

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

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

(iii) contact surfaces;

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

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

Order / Ordre :

(A4)
The licensee shall prepare, submit and implement the following:

1. Cleaning procedures that include how every resident room and ensuite washroom will be thoroughly cleaned (daily clean and deep clean) to ensure that dust and visible matter is removed from floors, furnishings, walls (including baseboards), heaters, window sills, doors, ceiling fixtures and vents, including what solutions and supplies/equipment are to be used; and
2. A schedule that includes adequate time for housekeeping staff to clean each type of room (whether a daily clean or a deep clean) in accordance with the cleaning procedures; and
3. Procedures that include how the kitchen walls, floors, ceilings, exhaust hood, fixed equipment (tables, oven, steamer, fridges), steam tables, three compartment sink, dishwasher, dishwasher trays, floor mats, drains, shelving are to be cleaned including what type of solutions and supplies/equipment are to be used; and
4. How often and how each resident room and kitchen will be evaluated to ensure the cleaning standards have been met.
5. A floor stripping and re-waxing schedule for all areas of the home that have wax flooring and that includes who will conduct the stripping and re-waxing.
6. A buffing schedule for all areas of the home that have wax flooring and who will conduct the buffing.
7. All dietary aides shall have input in developing the kitchen cleaning schedules and procedures and all housekeepers shall have input in developing the resident room/washroom cleaning schedules and procedures.

The plan shall be submitted to Bernadette.susnik@ontario.ca for review by March 31, 2018 and all schedules and procedures implemented by August 31, 2018.

Grounds / Motifs :

1. This order is based on the application of the factors of severity (1), scope (3) and compliance history (4) in keeping with O. Reg 79/10, s. 299. This is in respect to the severity of minimal harm, the scope of widespread and the licensee's history of non-compliance that included: voluntary plans of corrective action (VPC) issued in 2016

and a WN in 2015 and s. 72 (7) which is a similar area.

As part of the organized program of housekeeping under clause 15(1)(a) of the Act, the licensee did not ensure that procedures were developed and implemented for cleaning of the home.

As part of the organized program of housekeeping under clause 15(1) (a) of the Act, the licensee did not ensure that procedures were developed and implemented for cleaning of the home.

i. Numerous portable air conditioning units were observed in the home, located in the windows of various resident rooms which had dusty filters and a black substance that resembled mould on the surface of the directional louvers. The housekeepers reported that they did not clean the air conditioning units. The maintenance person, who had been with the home for just over a year reported that he had not cleaned or inspected the units. According to procedure #2400 located in the maintenance procedures manual provided by the Environmental Services Supervisor, air conditioners were to be cleaned on a monthly basis and the units were to be inspected for dirt and debris accumulations on the coil fins on a quarterly basis.
ii. Several resident rooms were observed on an identified date in December 2017, were noted to have accumulated dust under and around furnishings, on and under heaters, visible matter on walls in both the bedrooms (near beds) and bathrooms (under vanities and near toilets), dusty ceiling lift spreader bars and motors, dusty exhaust vents in washrooms and cob webbing in corners. In particular, one room had a significant amount of accumulated matter on an over bed table base and on a piece of medical equipment. A return visit was made to the identified rooms on another date in December 2017, and the room sanitation did not appear any different. Several rooms were signed off by a housekeeper as deep cleaned on an identified dates in December 2017, these rooms continued to have a significant amount of soiling on the over bed tables and on the medical device.
According to the home's "Housekeeper 2 and 3 Routine" which broke down tasks by time, high dusting or the need to clean walls in bedrooms was not included, however staff were required to mop the floor, clean furniture and clean various surfaces, including walls in bathrooms. The ESS and housekeeping staff confirmed that two housekeepers were allocated for the three story building at eight hours each per day (minus breaks). Seven hours had to be divided up per housekeeper so that each housekeeper was required to clean 16 resident rooms and ensuite washrooms (four hours if cleaned within 15 minutes), the corridors, stairwells, tub/shower room,

nursing station, utility room and dining/lounge room. Once completed, each housekeeper was required to split the cleaning of the lowest level which included two visitor washrooms, hair salon, five offices, corridor, entry foyer, staff change room and washroom, staff lunch room, laundry, activity room, and a large dining room. Not allocated on the daily cleaning schedule was the requirement to deep clean one room per day. According to housekeeping staff, each room was required to be deep cleaned on a daily basis per floor which, depending on the size, took approximately one hour. According to the ESS, the expectation was that during the deep cleaning process, all furniture was supposed to be moved, every surface cleaned and drapes and privacy curtains washed (if soiled).
iii. Tub lift chairs located in the tub rooms were both observed to have a yellow layer of soap scum on the underside of the seats on an identified dates in December 2017. The scum layer was easily removed by the inspector with paper towel. According to PSWs, the cleaning of the chairs was a task assigned to PSWs who gave a tub bath to residents and included cleaning the tub after each bath. Brushes were provided and noted in tub rooms for this task. Cleaning instructions were observed posted on the wall of one tub room and cleaning and disinfecting procedures were available for tub lift chairs and tubs, which required that they be cleaned and disinfected after each use. One PSW was shown the scum layer of the lift seat in the third floor tub room and stated they would clean it on an identified date in December 2017. However, upon a return visit on another date in December 2017, the layer of scum was still present.
iv. The majority of resident rooms and resident ensuite washrooms were observed to have darkening along the perimeter (along baseboards) of the bedrooms with poly vinyl chloride (VPC) floor tiles and the flooring material appeared dirty, with traffic patterns, scuffs and stuck on debris. The baseboards had old wax, paint and stuck on debris. Certain resident washrooms also had adhesive bleeding out from between the 12 inch VPC floor tiles. According to email records, the Administrator sent a directive to the ESS to have staff remove the adhesive on an identified date in November 2017. However, the ESS reported that the adhesive could not be removed with the method that was employed. Housekeeping staff used brushes and standard cleaning products which did not have an impact on the adhesive. An appropriate adhesive remover was not used.

The home's procedure (05-03-05-A2) included a routine for light floor scrubbing and resurfacing cleaning and a spray buffing frequency for lounges, corridors and resident rooms. The "Floor spray buffing cleaning procedure" required that floors be cleaned (using a floor machine) to remove scuffs, marks and ground in dirt once per

month in resident bedrooms. Their floor stripping and re-waxing policies included suggested frequencies for stripping and re-waxing and was based on high or low traffic patterns.

According to housekeeping staff and the maintenance person, no buffing or removal of old wax and re-waxing was scheduled over the last year. During prior years, a rotational schedule had been developed and housekeeping staff reported that floors were stripped and re-waxed. No schedule had been established at the time of the visit to address the floor care issues and the existing procedures were not implemented.

vi. The main kitchen was toured with the ESS on an identified date in December 2017. At that time, heavy matter was splattered on the walls and was noted in and around the steam table in the small servery area and in and around the dish wash area. Heavy build-up of food debris noted on the underside of the stainless steel dish wash table. Moderate amounts of food debris build up noted on the doors of the dish wash machine. Heavy dust accumulation was noted on the screen over the dish wash machine. Heavy scale build-up noted in steam wells of several steam table units, according to the dietary aide who was tasked at cleaning them, an appropriate de-scaler was not used. Some black spots and food splatter noted on the ceiling. The ESS reported that cleaning of the walls and equipment were on the daily cleaning schedule and were tasked out to various dietary aides and the cook.

Based on the above noted observations, the tasks or procedures were not implemented.
(120)

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

Aug 31, 2018(A3)

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 : 006

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

Pursuant to / Aux termes de :

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

(a) cleaning of the home, including,

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

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

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

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

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

(iii) contact surfaces;

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

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

Order / Ordre :

The licensee shall complete the following:

1. Remove all air conditioners from resident room windows and any located in common areas frequented by residents as soon as the outdoor air temperature exceeds 15C.
2. The air conditioning units shall not be re-installed unless fully cleaned of dust and mould and are inspected for proper operation according to manufacturer's instructions.
3. Amend the existing procedure titled "Air Conditioners #2400" to include who is responsible for ensuring air conditioners are cleaned as frequently as necessary to prevent a build-up of dust and mould growth, when they are to be removed or installed and by whom, if they are to be left installed year round, how the unit will be sealed to prevent insects from entering the room or cold air drafts from entering the room and how the air conditioners will be managed if they are not owned by the licensee. A copy of the procedure shall be submitted to Inspector #120 by March 31, 2018.

Grounds / Motifs :

(A3)
1. This order is based on the application of the factors of severity (1), scope (3) and compliance history (4) in keeping with O. Reg 79/10, s. 299. This is in respect to the severity of minimal harm, the scope of widespread and the licensee's history of non-compliance that included: voluntary plans of corrective action (VPC) issued in 2016 and a WN in 2015 and s. 72 (7) which is a similar area.

As part of the organized program of housekeeping under clause 15(1)(a) of the Act, the licensee did not ensure that procedures were developed and implemented for cleaning of the home.

i. Numerous portable air conditioning units were observed in the home, located in the windows of various resident rooms. Units located in but not limited to identified rooms had very dusty filters and a black substance that resembled mould on the surface of the directional louvers. The housekeepers reported that they did not clean the air conditioning units. The maintenance person, who had been with the home for just over a year reported that he had not cleaned or inspected the units. According to procedure #2400 located in the maintenance procedures manual provided by the Environmental Services Supervisor, air conditioners were to be cleaned on a monthly basis and the units were to be inspected for dirt and debris accumulations on the coil fins on a quarterly basis.
ii. Resident identified rooms were observed on an identified date in December 2017, to have accumulated dust under and around furnishings, on and under heaters, visible matter on walls in both the bedrooms (near beds) and bathrooms (under vanities and near toilets), dusty ceiling lift spreader bars and motors, dusty exhaust vents in washrooms and cob webbing in corners. In particular a specified room had a significant amount of accumulated matter on an over bed table base. A return visit was made to identified rooms on an identified date in December 2017, and the room sanitation did not appear any different. Specified rooms were signed off by a housekeeper as deep cleaned on an identified dates in December 2017, which continued to have a significant amount of soiling on the over bed table was last signed off as deep cleaned on an identified date in December 2017.

According to the home's "Housekeeper 2 and 3 Routine" which broke down tasks by time, high dusting or the need to clean walls in bedrooms was not included, however staff were required to mop the floor, clean furniture and clean various surfaces, including walls in bathrooms. The ESS and housekeeping staff confirmed that two housekeepers were allocated for the three story building at eight hours each per day (minus breaks). Seven hours had to be divided up per housekeeper so that each housekeeper was required to clean 16 resident rooms and ensuite washrooms (four hours if cleaned within 15 minutes), the corridors, stairwells, tub/shower room, nursing station, utility room and dining/lounge room. Once completed, each housekeeper was required to split the cleaning of the lowest level which included two visitor washrooms, hair salon, five offices, corridor, entry foyer, staff change room and washroom, staff lunch room, laundry, activity room, and a large dining room. Not allocated on the daily cleaning schedule was the requirement to deep clean one room per day. According to housekeeping staff, each room was required to be deep cleaned on a daily basis per floor which, depending on the size, took approximately

one hour. According to the ESS, the expectation was that during the deep cleaning process, all furniture was supposed to be moved, every surface cleaned and drapes and privacy curtains washed (if soiled).
iii. Tub lift chairs located in the tub rooms were both observed to have a yellow layer of soap scum on the underside of the seats on identified dates in December, 2017. The scum layer was easily removed by the inspector with paper towel. According to PSWs, the cleaning of the chairs was a task assigned to PSWs who gave a tub bath to residents and included cleaning the tub after each bath. Brushes were provided and noted in tub rooms for this task. Cleaning instructions were observed posted on the wall of one tub room and cleaning and disinfecting procedures were available for tub lift chairs and tubs, which required that they be cleaned and disinfected after each use. One PSW was shown the scum layer of the lift seat in the tub room and stated they would clean it on an identified date in December 2017. However, upon a return the layer of scum was still present.
iv. The majority of resident rooms and resident ensuite washrooms were observed to have darkening along the perimeter (along baseboards) of the bedrooms with poly vinyl chloride (VPC) floor tiles and the flooring material appeared dirty, with traffic patterns, scuffs and stuck on debris. The baseboards had old wax, paint and stuck on debris. Certain resident washrooms also had adhesive bleeding out from between the 12 inch VPC floor tiles. According to email records, the Administrator sent a directive to the ESS to have staff remove the adhesive on an identified date in November 2017. However, the ESS reported that the adhesive could not be removed with the method that was employed. Housekeeping staff used brushes and standard cleaning products which did not have an impact on the adhesive. An appropriate adhesive remover was not used.

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visit to address the floor care issues and the existing procedures were not implemented.

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Based on the above noted observations, the tasks or procedures were not implemented. (120)

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

Mar 31, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

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

Issued on this 18 day of June 2018 (A4)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by BERNADETTE SUSNIK - (A4)

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 : Hamilton