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

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 2, 2018	2018_751649_0017	020206-18	Resident Quality Inspection

Licensee/Titulaire de permis

City of Toronto
55 John Street Metro Hall, 11th Floor TORONTO ON M5V 3C6

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

Carefree Lodge
306 Finch Avenue East NORTH YORK ON M2N 4S5

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

JULIEANN HING (649), SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): on August 30, 31, September 4, 5, 6, 7, 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, and 28, 2018.

This inspection was conducted concurrently with compliant inspection report #2018_751649_0018. A Written Notification (WN) and Voluntary Plan of Correction (VPC), related to S.O. 2007 c.8 s. 6 (2), s. 6 (9), r. 131 (1) and a WN and Compliance order (CO) related to S.O. 2007 c.8 s. 19 (1) was identified in this inspection #2018_751649_0018 and has been issued in this report #2018_751649_0017, dated November 2, 2018.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Nurse Manager (CNM), Manager of Resident Services, Physiotherapist (PT), Counsellor, registered nurses (RNs), registered practical nurses (RPNs), Resident Assessment Instrument - Minimum Data Set (RAI-MDS) back-up, personal support workers (PSWs), recreation services assistant (RSA), private caregivers, residents and family members.

During the course of the inspection the inspector(s) conducted a tour of the home, observed delivery of resident care and services, observed staff to resident interactions, observed medication administration and reviewed the licensee's medication incidents, reviewed resident's health records, staff training records, minutes of residents and family council, reviewed relevant policies and procedures, and conducted resident and family interviews.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 has failed to ensure that residents #004 and #037 were not neglected by the licensee or staff.

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

Resident #004 triggered from stage one of the Resident Quality Inspection (RQI) for altered skin integrity.

Record review below confirmed that the resident was assessed as having pain and no pain management interventions administered to provide relief to the resident.

- Record review of the resident's skin assessment completed on an identified date indicated that the resident had areas of altered skin integrity. The pain assessment indicated moderate pain and identified activities made the pain worse. Progress note on the same day indicated that the resident was "agitated and resistive during care".

- Progress note documentation on another identified date indicated that the resident had "mild pain".

- The resident was assessed by the Enterostomal therapist (ET) on an identified date and their documentation indicated that the area of altered skin integrity was "painful to touch".

- Pain assessments documented using the Abbey pain assessment tool and the Edmonton Symptom Assessment System (ESAS) completed on identified dates indicated that the resident had mild pain.

- Progress note on an identified date indicated that a pain assessment was completed and on the physician list for analgesia – no orders received from the physician.

- A review of the resident's MAR indicated there was no documentation that pain medication had been administered to the resident when there was documentation that the resident was having pain.

During interviews with the CNM #120 and RN #105, they confirmed that resident #004 had not been administered any pain medication on identified dates when there were assessments and documentation that the resident was having pain.

During interviews with the Administrator, DOC and the CNM #120, they confirmed that neglect had occurred based on the above definition with resident #004 as no pain medication or interventions had been administered.

2. The home submitted a Critical Incident System (CIS) report related to improper care of resident #027. Review of a complaint received by the Ministry of Health and Long-Term Care (MOHLTC) indicated that the resident was receiving improper care and was being neglected in regards to their toileting needs.

Documents sent to the MOHLTC with the above complaint were reviewed. On an identified date the SDM came to the home to find resident #027 soaked in urine in an identified area of the home. PSW #132 told the SDM that the resident did not get changed before dinner because they had a meeting. After dinner, when helping to change the resident, the SDM noted that the resident had developed an identified condition. The next day, the SDM noted that the resident needed changing before lunch but their primary care giver, PSW #133 was nowhere to be found and when located, refused to provide care as they were going on break. As a result, RN #130 and PSW #102 completed continence care for the resident. According to the SDM, they had been expressing their concerns about the lack of toileting and improper care over an identified period of time. The SDM stated that a meeting with the DOC occurred on an identified date where it was agreed that there had been unacceptable nursing care.

Other documents included with the complaint included an incident on an identified date

where the SDM indicated that they were shocked to find resident #027's mobility device soiled with urine. On another identified date the SDM noted that the resident's had developed an identified condition and while watching care being provided, noted that the care giver was not providing care correctly. According the note, the SDM spoke with the registered staff and had a meeting with the DOC regarding these concerns.

During an interview with the complainant, they indicated that all of their concerns had been resolved and were currently satisfied with the care being provided. The SDM stated that for the time that PSW #133 had provided care for resident #027, the resident was constantly left in urine soaked briefs which often saturated the resident's mobility device. As a result, the SDM stated that they had to clean and sanitize the device daily. Since PSW #133 had no longer been providing care to the resident since an identified date there have been no problems with toileting and the device is fine to be cleaned according the home's schedule.

Review of an ad hoc resident conference on an identified dated indicated resident #027's SDM was concerned about the care the resident was receiving and stated they were very concerned about the times the resident was being changed and the amount of time the resident was spending in an incontinent product. The RPN who took notes for this conference documented that they explained that the resident was to be changed once per shift and as needed.

The home was unable to provide any continence assessments completed for resident #027 since admission.

Review of the home's investigation notes indicated that during an investigation meeting, PSW #132 admitted that on an identified date was the first time they were assigned to provide care for resident #027 and they had not checked the care plan. The PSW also admitted that they knew the resident was to be changed before dinner but did not have time because they were in a meeting and had explained that to the SDM. As well, when the PSW did provide perineal care to the resident after dinner, they failed to do so properly. Review of a letter of expectation to PSW #132 on an identified dated stated that based on the information gathered, it was determined that they violated the standard for neglect by failing to provide the care and assistance required for health, safety or well-being of residents.

During an interview with PSW #132, they admitted that they had not checked resident #027's written plan of care prior to providing care for resident #027 on an identified date.

However, the PSW indicated that they were aware that the usual routine for resident #027 was to have their brief changed before dinner. Due to a meeting and other duties to attend to, PSW #132 stated they did not have time to change resident #027's brief before dinner. PSW #132 stated that when providing care for resident #027, they noticed that there was discharge and did not think that this had just happened and had been aware that the lack of regular toileting had been an ongoing issue with PSW #133.

During an internal investigation meeting with PSW #133, it was documented that the PSW stated to RN #130 on an identified dated that they were not going to help toilet resident #027 because they were going on break and the RN would have to get someone else to help.

During interviews with RN #130 and PSW #102, they revealed that even though PSW #133 was resident #027's primary care giver, PSW #133 refused to help toilet the resident on an identified date because they were going on break. An interview with PSW #133 was not possible as they were on an extended leave of absence.

During an interview with Administrator #113, they acknowledged that the home failed to ensure that resident #027 was free from neglect by the staff in the home.

3. A complaint was submitted to the MOHLTC alleging concern about resident#037's nail care and that bath/shower were not provided during an identified period. The complainant also reported that the resident's SDMs had not been notified about the administration of an identified medication.

A review of the resident progress notes for an identified period did not indicate any documentation about nail care until the resident's family member expressed concern to the home on an identified date and the resident was subsequently seen by the chiropodist.

According to the resident's podiatry notes they had nail service on an identified date and the next service was approximately two years later. Interview with the Chiropodist #142 confirmed that the resident had not received any podiatry service during this period.

During interviews with the Administrator DOC #101, CNM #120, and RN #137, they acknowledged the resident's nails care had not been completed and confirmed that neglect of the resident had occurred based on the above definition of neglect. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 resident #037 was not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

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

Resident #001 triggered from stage one of the RQI for potential restraints related to their mobility device. On September 5, 2018, at 0907 and 1021 hours, the inspector observed the resident to have a safety device attached to their mobility device during and after

breakfast. The inspector did not see the resident in the mobility device at any time after stage one.

Review of resident #001's current written plan of care indicated the resident was totally dependent for transfer and there was no indication that the resident was using a safety device. A progress note made by the PT on an identified date indicated the resident was using two safety devices and the PT would speak with the family regarding the home's no restraint policy. The progress note also stated that the safety device will be used only for positioning, postural support and ADLs.

During an interview with RPN #104, they indicated that resident #001 only uses the safety device when the resident is performing ADLs or other identified activities. The RPN also indicated that the resident would not be able to remove the safety device on their own. During an interview with RN #105, they indicated that resident #001 has a safety device because the family wanted it and the resident uses it when performing identified activities. The RN indicated the resident is unable to get up from the mobility aid and therefore the safety device did not have any restraining qualities.

During an interview with PT #106, they stated they did not recommend the use of the safety device but if the family insisted, then it should be documented as a Personal Assistance Service Device (PASD) and be part of the care plan.

During an interview with DOC #101, they stated that it is the expectation of the home that the use of this particular safety device be part of resident #001's written plan of care so that staff are aware of what it is being used for and when to apply it. [s. 6. (1) (a)]

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

Resident #002 triggered from stage one of the RQI for environment not accommodating.

During an interview, the resident told the inspector that they are unable to access the washroom attached to their private room because the door is not wide enough for their mobility device. The resident stated that they would like to access the tap and sink in the washroom. According to the resident, they would like to be more independent and perform personal grooming all of which require running water. The resident indicated they get agitated having to wait for someone to help with getting access to water. The resident stated that they had not brought this concern to the home's attention because

they did not see there was any point.

During an interview with PSW #111, they stated resident #002 can perform their own personal hygiene but because the resident cannot access their sink, a basin of water is provided for the resident on a table. According to PSW #111, resident #002 likes to do as much as they can. During an interview with RN #112, they stated that resident #002 could be much more independent and perform some activities of daily of living if they had access to a sink.

During an interview with the home's Counsellor/Social Worker, they stated they were unaware that resident #002 had issues with not being able to access their washroom and could look into putting the resident's name on a waiting list for a room that has a mobility device accessible washroom.

During an interview with RSA #113, they stated resident #002 is passionate about an identified activity and confirmed that there was nothing in their plan of care to provide water to the resident for that activity. The RSA acknowledged that this area should be assessed and be part of the resident's plan of care.

During an interview with Administrator (#114), they stated they were unaware of resident #002's above mentioned needs and acknowledged that resident #002 should be assessed for not being able to access water on their own so that a plan of care can be created. The Administrator also admitted that the home should support resident #002 to be as independent as possible. [s. 6. (2)]

3. (a) Resident #007 triggered from stage one of the RQI for altered skin integrity.

The resident's weekly wound assessment record for an identified period indicated that the altered skin integrity had deteriorated.

Observations on September 6 and 7, 2018, at approximately 1126 and 1025 hours respectively, revealed that the resident was sitting on an identified device while up in their mobility device.

During an interview with PSW #107, they told the inspector that they have been leaving the identified device under the resident when up in the mobility device since they started to work with the resident. According to the PSW when the identified device was removed from the resident it was difficult to reapply and acknowledged that they did not think

sitting on the identified device provided any benefit to the resident's altered skin integrity.

During an interview with PT #106, they told the inspector that the resident had been receiving an identified treatment to an area of altered skin integrity and stated that the purpose of the treatment was to help prevent infection and promote healing. According to the PT, best practice did not recommend any use of an identified device on the resident's mobility device as it minimizes the benefit of the cushion.

During an interview with RPN #115, they stated that the resident should not have been sitting on the identified device while up in the mobility device and acknowledged they had previously seen the resident sitting on the identified device.

During an interview with DOC #101, they acknowledged that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident and the use of the identified device was not mentioned in the resident's plan of care.

(b) The home submitted a CIS report related to improper care of resident #027. Review of a complaint received by the MOHLTC indicated that the resident was receiving improper personal care and was being neglected in regards to their toileting needs.

Documents sent to the MOHLTC with the above complaint were reviewed. On an identified date the SDM came to the home at dinner time to find resident #027 soaked in urine in an identified area of the home. PSW #132 told the SDM that the resident did not get changed before dinner because they had a meeting. After dinner, when helping to change the resident, the SDM noted that the resident had developed an identified condition. The next day, the SDM noted that the resident needed changing before lunch but their primary care giver, PSW #133 was nowhere to be found and when located, refused to provide care as they were going on break. As a result, RN #130 and PSW #102 completed continence care for the resident. According to the SDM, they had been expressing their concerns about the lack of toileting and improper care over an identified period of time. The SDM stated that a meeting with the DOC occurred on an identified date where it was agreed that there had been unacceptable nursing care.

Other documents included with the complaint included an incident on an identified date where the SDM indicated that they were shocked to find resident #027's mobility device soiled with urine. On another identified date the SDM noted that the resident's had an identified condition and while watching care being provided, noted that the care giver was

not providing care correctly. According the note, the SDM spoke with the registered staff and had a meeting with the DOC regarding these concerns.

During an interview with the complainant, they indicated that all of their concerns had been resolved and were currently satisfied with the care being provided. The SDM stated that for the time that PSW #133 had provided care for resident #027, the resident was constantly left in urine soaked briefs which often saturated the resident's mobility device. As a result, the SDM stated that they had to clean and sanitize the device daily. Since PSW #133 had no longer been providing care to the resident since an identified date there have been no problems with toileting and the device is fine to be cleaned according the home's schedule.

Review of an ad hoc resident conference on an identified dated indicated resident #027's SDM was concerned about the care the resident was receiving and stated they were very concerned about the times the resident was being changed and the amount of time the resident was spending in an incontinent product. The RPN who took notes for this conference documented that they explained that the resident was to be changed once per shift and as needed.

The home was unable to provide any continence assessments completed for resident #027 since admission.

Review of an investigation meeting with PSW #125, indicated that they provided care for resident #027 on an identified date and were unaware the resident had of any special care needs. According to this statement, PSW #125 did not provide proper care.

During an interview with PSW #125, they admitted that they were unaware of how to properly provide care.

During an interview with DOC #101, they acknowledged that resident #027 should have been assessed and the plan of care should have included specifics on how to properly provide care. [s. 6. (2)]

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

Resident #007 triggered from stage one of the RQI for altered skin integrity.

A review of the home's record titled resident turning/ positioning schedule worksheet for resident #007 and staff interviews confirmed there were gaps in the documentation for an identified period.

During an interview with PSW #107 who had worked with the resident on identified dates told the inspector they had turned and repositioned the resident every two hours but had forgotten to document.

During an interview with PSW #108 who had worked with the resident on identified dates told the inspector that they had turned and repositioned the resident every three to four hours but was unable to say why they had not documented.

During an interview with PSW #117 who worked with the resident on an identified dates told the inspector that they had turned and repositioned the resident every two hours but forgotten to document.

During interviews with the DOC #101, RPN #115 and RPN #135, they acknowledged that the resident's turning and repositioning should have been documented.

5.A complaint was submitted to the MOHLTC alleging concern about resident #037's nail care and that bath/shower were not provided during an identified period. The complainant also reported that the resident's SDMs had not been notified about the administration of an identified medication.

A review of the nursing and personal care record (NPCR) for resident #037 related to bathing indicated it had not occurred during an identified period of time.

A review of progress notes for an identified period indicated the resident family member assisted with the resident showers on identified dates.

During an interview with RN #137 they told the inspector that residents were provided with a bath/shower twice a week and this provision of care was documented in the Nursing & Personal Care Record (NPCR). According to RN #137 if resident #037 refused their shower the PSWs should report to the registered staff so they can monitor how often the resident had refused.

During an interview with CNM #120 they acknowledged that the resident showers were not documented in the NPCR and stated that the PSWs should report to the nurse who

will document in the progress notes to see how often the resident had refused their showers.

During an interview with DOC #101, they told the inspector that showers were documented in the NPCR and confirmed that most of the resident showers did not occur during the above mentioned periods. According to the DOC if the PSW was unable to give the resident their shower they would report to the registered staff to explore alternatives and notify the family. [s. 6. (9) 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 that there is a written plan of care for each resident that sets out the planned care for the resident, the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, the provision of care set out in the plan of care are documented, and the outcomes of the care set out in the plan of care were documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with O. Reg. 79/10, s.114 (1) the licensee shall ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

A review of the home's policy titled shift change monitored drug count, dated February 2017 revised January 2018 directs staff:
Two staff (leaving and arriving), together:
-Count the actual quantity of medications remaining
-Record the date, time, quantity of medication and sign in the appropriate spaces on the "shift change monitored medication count" form
-Confirm actual quantity is the same as the amount recorded on the "individual monitored medication record" for PRN, liquid, patches or injectable.

On September 17, 2018, at approximately 0720 hours the inspector observed RPN #121 counting the controlled substances on an identified home area by themself.

During an interview with RPN #121, they confirmed that they had been counting the controlled substances by themselves and stated the registered nurse who had worked the night shift was busy doing an incident report.

During an interview, the DOC told the inspector that according to the homes' policy, two registered staff: incoming and outgoing must sign that the controlled substances count was correct. [s. 8. (1) (b)]

2. In accordance with O. Reg. 79/10, s.136. (1) (a) the license shall ensure, as part of the medication management system, that a written policy was developed in the home that provides for the ongoing identification, destruction and disposal of all expired drugs.

A review of the home's policy titled recommended expiry dates once product is open dated April 2017 revised January 2018 indicated that an identified inhaler expiry date once open is four weeks.

Observation of resident #011's medication administration on September 21, 2018, at approximately 0838 hours by RPN #121 revealed that the resident was administered an identified inhaler. The identified inhaler had an open date of June 1, 2018.

During an interview RPN #121 confirmed that the identified inhaler should have been replaced with a new one every four weeks after the open date of June 1, 2018.

During an interview DOC #101 told the inspector that the pharmacy should have been notified and a new inhaler obtained. In response to if there was any medication in the identified inhaler opened on June 1, 2018, the DOC replied that they did not think so. [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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

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

Resident #004 triggered from stage one of the RQI for altered skin integrity.

A review of the home's policy titled skin care and wound prevention and management, policy #RC-0518-02, published January 4, 2016, directs the registered staff to reassess all wounds using the ulcer/wound assessment record weekly or more frequently as indicated.

According to the weekly assessment record the resident had an area of altered skin integrity that had healed. Further review of the resident's weekly skin assessments completed during an identified period, indicated inconsistencies in the assessments.

During an interview RN #112 told the inspector that their guess was that the assessment had not been completed as there was a gap in the assessments and acknowledged that a weekly assessment should have been completed.

During an interview, the DOC confirmed that a weekly skin and wound assessment should have been completed for the altered skin integrity during an identified period. [s. 50. (2) (b) (iv)]

2. Resident #007 triggered from stage one of the RQI for altered skin integrity.

A review of the home's policy titled skin care and wound prevention and Management, policy #RC-0518-02, published January 4, 2016, directs the registered staff to reassess all wounds using the ulcer/wound assessment record weekly or more frequently as indicated.

According to the weekly assessment record the resident had an area of altered skin integrity. Further review of the resident's weekly skin assessments completed during an identified period, indicated inconsistencies in the assessments.

During interviews with the DOC, RPN #115 and RPN #135 confirmed that the weekly assessment record for resident #007 had not been completed during an identified period. [s. 50. (2) (b) (iv)]

3. Resident #009 triggered from stage one of the RQI for an altered skin integrity.

A review of the home's policy titled skin care and wound prevention and management, policy #RC-0518-02, published January 4, 2016, directs the registered staff to reassess all wounds using the ulcer/wound assessment record weekly or more frequently as indicated.

According to the weekly skin assessment record indicated the resident had an area of altered skin integrity that had healed. Further review of the resident's weekly skin assessments completed during an identified period, indicated inconsistencies in the assessments.

During interviews with the DOC and RN #105 confirmed that no weekly skin assessment had been completed during an identified period. [s. 50. (2) (b) (iv)]

4. The licensee has failed to ensure that any resident who is dependent on staff for repositioning was repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.

Resident #007 triggered from stage one of the RQI for altered skin integrity.

A review of the resident's most recent care plan indicated that the resident had an area of altered skin integrity evidenced by several factors. According to the resident's most recent care plan and RAI-MDS assessment indicated that the resident was on a turning and repositioning program every two hours.

According to the resident's weekly assessment record for an identified period indicated that an area of altered skin integrity had deteriorated.

During an interview PSW #108 told the inspector that they have been turning and repositioning the resident every three to four hours and confirmed that they had been aware that the resident had altered skin integrity.

During interviews with the DOC, RPN #115 and RPN #135, they confirmed that turning and repositioning the resident every three to four hours was not following the resident's plan of care and the home's expectation. [s. 50. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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 staff, if clinically indicated, and any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that they seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results.

During an interview, the Family Council Assistant #100 told the inspector that the survey titled your opinion counts (YOC) had been sent directly from their division to the families and the family responses were returned directly to the division and did not come to the home.

According to the Family Council Assistant the last Family Council meeting before they break for the summer was held on an identified date, and the home received the YOC questions after the Council had break for the summer. The Family Council Assistant stated that they had hoped to discuss the YOC at the next upcoming meeting but the families had already received the YOC survey.

During an interview the Administrator told the inspector that the home's normal process is to have the Family Council provide their feedback to the division and stated this year there had been a delay in terms of the time the home received the survey and did not seek the advice of the Family Council in developing and carrying out the survey. [s. 85. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that they seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

On August 30, 2018, during the initial tour of the home, the inspector observed that a shower room was unlocked. Inside the room was a spray bottle containing Oxiver Tb, a surface cleaner and intermediate disinfectant. During an interview with DOC #101, they confirmed that this was a hazardous substance and should not be accessible to residents.

On September 20, 2018, the inspector observed another shower room was propped open with a towel. Inside the room was a spray bottle containing Oxiver Tb. During an interview with CNM #120, they confirmed that this was a hazardous substance and should not be accessible to residents. [s. 91.]

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 hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

During observation of a medication pass on September 13, 2018, on an identified home unit, the inspector observed resident #008's medications in the strip packaging and poured medication were left on top of the medication cart when the nurse was not in attendance. Then RPN #118 retrieved the medication strip belonging to resident #008 and realized that one of the resident's medication was not in the mediation cart. The nurse locked the medication cart leaving the resident's medication strip on top of the cart to get the missing medication.

While the medication strip was observed on top of the medication cart, resident #010 came out of their room in their and went down the hall towards the nursing station.

RPN #118 returned to the medication cart and poured an identified medication into a drinking glass and realized they were missing a second medication for the resident. The nurse put the medication strip in the top drawer of the medication cart, locked the cart and left the poured medication in a drinking glass on top of the medication cart.

During an interview with RPN#118, they told the inspector that the resident's medications were in another medication cart and they did not realized that the resident was getting these medications. RPN #118 acknowledged that they should have stored the resident's medications in the locked medication cart when they stepped away from the medication cart.

During an interview with the DOC #101, they confirmed that medications should not have been left on top of the medication cart when the nurse was not in attendance. [s. 129. (1) (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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #011 was randomly selected for a medication observation as a result of non-compliance with resident #008.

A review of the resident's current Medication Administration Record (MAR) and the last quarterly review for an identified period indicated to give an identified medication one tablet by mouth daily and not to crush the medication. On this same MAR and quarterly review under the notes section stated to "crush meds".

Observation of the resident's medication administration on an identified date by RPN #121 revealed that the resident was given an identified medication crushed in apple sauce.

During an interview with RPN #121, they confirmed they had given resident #011 their medication crushed in apple sauce and stated they had not paid attention to the actual medication order: do not crush.

During an interview DOC #101 acknowledged that the above medication was not administered to the resident in accordance with the directions for use specified by the prescriber.

2. A complaint was submitted to the MOHLTC for resident#036 alleging inappropriate force during care, resulted in the resident sustaining an injury.

Review of the resident's MAR indicated that they had been prescribed a scheduled medication three time a day. The nurse took the scheduled medications to the resident's room, but the resident was asleep. According to the progress notes the scheduled medications were wasted by two nurses.

The nurse who documented the above entries was no longer working at the home and not available for an interview.

During interviews, DOC #101 and CMM #120 confirmed that the resident's medication had not been administered to the resident in accordance with the directions for use specified by the prescriber. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's written record was kept up to date at all times.

Resident #004 triggered from stage one of the RQI for altered skin integrity.

A request of the resident's MAR for an identified period indicated only a partial MAR record was available and the second page of the resident's MAR could not be found.

During interviews with the DOC and RN #105, they acknowledged that the resident's second page of their MAR could not be located when it had been requested by Inspector #649. [s. 231. (b)]

2. Resident #007 triggered from stage one of the RQI for altered skin integrity.

A review of the home's record titled resident turning/ positioning schedule worksheet for resident #007 and staff interviews confirmed that the resident had been on a turning and repositioning schedule. Record review and staff interviews confirmed that the resident turning/ positioning schedule worksheet for an identified period could not be found when it had been requested by Inspector #649.

During interviews with DOC #101, RPN #115 and RPN #135, they confirmed that the licensee had failed to ensure that the resident's written record had been kept up to date at all times as the resident's turning/ positioning schedule worksheet could not be located. [s. 231. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's written record is kept up to date at all times, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

A review of the Family Council meeting minutes on an identified date indicated the following concerns or recommendations were brought to the licensee's attention:

-Family member requested that screen in the dining room be pulled down due to too much light towards certain residents. The Family Council Assistant reported they will advise the Building Services Manager and will get back to the Family Council at the next meeting.

-Concern from a family member that staff refuses to allow family members to take other residents outside and wanted to know if family could be trained for this activity. The Administrator reported they will take this feedback and provide an update at the next Family Council meeting.

During an interview with the Family Council Assistant #100, they confirmed that both of the above mentioned concerns were brought up at the Family Council Meeting by the same family member. According to the Family Council Assistant they had notified the Building Service Manager and had provided a verbal response directly to the family member and acknowledged that a written response had not been provided to the Family Council. The Family Council Assistant confirmed after speaking with the Administrator that they had never responded to the Family Council on the concern of family members taking other residents outside.

During an interview with the Administrator, they acknowledged that the home did not follow the protocol and viewed the concern as a family concern rather than a concern from Family Council and should have responded to the council within 10 days. [s. 60. (2)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee did not comply with the conditions to which the license was subject. The Long-Term Care Home Service Accountability Agreement (LSSA) with the Local Health Integration Network (LHIN) under the Local Health Systems Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system.

Each resident's care and service needs shall be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the assessment reference date (ARD) of the previous assessment and will ensure that RAI-MDS tools are used correctly to produce an accurate assessment of the Health Care Service Provider's (HCSP) residents RAI-MDS Data.

The RAI-MDS 2.0 User's Manual Canadian Version September 2010 pp 209-211 defines a pressure ulcer as any lesion caused by pressure resulting in damage of underlying tissues. The manual further indicates to review the resident's record and consult with the nurse assistant about the presence of an ulcer, examine the resident, and determine the stage and number of any ulcer present.

Resident #004 triggered from stage one of the RQI for altered skin integrity.

According to the resident's weekly ulcer/ wound assessment record completed on identified date indicated the resident had an area of altered skin integrity.

During an interview with RN #119 who had completed the coding for the RAI-MDS assessment on an identified date acknowledged that the resident had an area of altered skin integrity and confirmed they should have included it on the RAI-MDS assessment.

During an interview the DOC acknowledged that the resident's altered skin integrity should have been included in the RAI-MDS assessment. [s. 101. (4)]

Issued on this 23rd day of November, 2018

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

Original report signed by the inspector.

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIEANN HING (649), SUSAN SEMEREDY (501)
Inspection No. / No de l'inspection :	2018_751649_0017
Log No. / No de registre :	020206-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 2, 2018
Licensee / Titulaire de permis :	City of Toronto 55 John Street, Metro Hall, 11th Floor, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	Carefree Lodge 306 Finch Avenue East, NORTH YORK, ON, M2N-4S5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bambo Oluwadimu

To City of Toronto, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 19 (1).

Specifically, the licensee shall ensure that residents #004 and #027 are protected from neglect by staff.

Upon receipt of this compliance order, the licensee shall prepare and submit a plan to ensure that residents #004 and #027 are protected from neglect by staff.

Specifically, resident #004 and any other residents experiencing pain:
Shall be provided with interventions as prescribed in the plan of care including the administration of analgesics for pain control.

Specifically, resident #027 and any other residents who are to be toileted:
Implement a system to monitor resident #027 and any other residents whose plan of care directs that they should be toileted as needed.

Please submit the plan to Julieann.hing@ontario.ca no later than November 19, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that residents #004 and #037 were not neglected by the licensee or staff.

Under O. Reg. 79/10, s.5 for the purpose of the definition of "neglect" in subsection 5 of the Act, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety

or well-being of one or more residents.

Resident #004 triggered from stage one of the Resident Quality Inspection (RQI) for altered skin integrity.

Record review below confirmed that the resident was assessed as having pain and no pain management interventions administered to provide relief to the resident.

- Record review of the resident's skin assessment completed on an identified date indicated that the resident had areas of altered skin integrity. The pain assessment indicated moderate pain and identified activities made the pain worse. Progress note on the same day indicated that the resident was "agitated and resistive during care".

- Progress note documentation on another identified date indicated that the resident had "mild pain".

- The resident was assessed by the Enterostomal therapist (ET) on an identified date and their documentation indicated that the area of altered skin integrity was "painful to touch".

- Pain assessments documented using the Abbey pain assessment tool and the Edmonton Symptom Assessment System (ESAS) completed on identified dates indicated that the resident had mild pain.

- Progress note on an identified date indicated that a pain assessment was completed and on the physician list for analgesia – no orders received from the physician.

- A review of the resident's MAR indicated there was no documentation that pain medication had been administered to the resident when there was documentation that the resident was having pain.

During interviews with the CNM #120 and RN #105, they confirmed that resident #004 had not been administered any pain medication on identified dates when there were assessments and documentation that the resident was having pain.

During interviews with the Administrator, DOC and the CNM #120, they confirmed that neglect had occurred based on the above definition with resident #004 as no pain medication or interventions had been administered.

2. The home submitted a Critical Incident System (CIS) report related to improper care of resident #027. Review of a complaint received by the Ministry of Health and Long-Term Care (MOHLTC) indicated that the resident was receiving improper care and was being neglected in regards to their toileting needs.

Documents sent to the MOHLTC with the above complaint were reviewed. On an identified date the SDM came to the home to find resident #027 soaked in urine in an identified area of the home. PSW #132 told the SDM that the resident did not get changed before dinner because they had a meeting. After dinner, when helping to change the resident, the SDM noted that the resident had developed an identified condition. The next day, the SDM noted that the resident needed changing before lunch but their primary care giver, PSW #133 was nowhere to be found and when located, refused to provide care as they were going on break. As a result, RN #130 and PSW #102 completed continence care for the resident. According to the SDM, they had been expressing their concerns about the lack of toileting and improper care over an identified period of time. The SDM stated that a meeting with the DOC occurred on an identified date where it was agreed that there had been unacceptable nursing care.

Other documents included with the complaint included an incident on an identified date where the SDM indicated that they were shocked to find resident #027's mobility device soiled with urine. On another identified date the SDM noted that the resident's had developed an identified condition and while watching care being provided, noted that the care giver was not providing care correctly. According the note, the SDM spoke with the registered staff and had a meeting with the DOC regarding these concerns.

During an interview with the complainant, they indicated that all of their concerns had been resolved and were currently satisfied with the care being provided. The SDM stated that for the time that PSW #133 had provided care for resident #027, the resident was constantly left in urine soaked briefs which often

saturated the resident's mobility device. As a result, the SDM stated that they had to clean and sanitize the device daily. Since PSW #133 had no longer been providing care to the resident since an identified date there have been no problems with toileting and the device is fine to be cleaned according the home's schedule.

Review of an ad hoc resident conference on an identified dated indicated resident #027's SDM was concerned about the care the resident was receiving and stated they were very concerned about the times the resident was being changed and the amount of time the resident was spending in an incontinent product. The RPN who took notes for this conference documented that they explained that the resident was to be changed once per shift and as needed.

The home was unable to provide any continence assessments completed for resident #027 since admission.

Review of the home's investigation notes indicated that during an investigation meeting, PSW #132 admitted that on an identified date was the first time they were assigned to provide care for resident #027 and they had not checked the care plan. The PSW also admitted that they knew the resident was to be changed before dinner but did not have time because they were in a meeting and had explained that to the SDM. As well, when the PSW did provide perineal care to the resident after dinner, they failed to do so properly. Review of a letter of expectation to PSW #132 on an identified dated stated that based on the information gathered, it was determined that they violated the standard for neglect by failing to provide the care and assistance required for health, safety or well-being of residents.

During an interview with PSW #132, they admitted that they had not checked resident #027's written plan of care prior to providing care for resident #027 on an identified date. However, the PSW indicated that they were aware that the usual routine for resident #027 was to have their brief changed before dinner. Due to a meeting and other duties to attend to, PSW #132 stated they did not have time to change resident #027's brief before dinner. PSW #132 stated that when providing care for resident #027, they noticed that there was discharge and did not think that this had just happened and had been aware that the lack of regular toileting had been an ongoing issue with PSW #133.

During an internal investigation meeting with PSW #133, it was documented that the PSW stated to RN #130 on an identified dated that they were not going to help toilet resident #027 because they were going on break and the RN would have to get someone else to help.

During interviews with RN #130 and PSW #102, they revealed that even though PSW #133 was resident #027's primary care giver, PSW #133 refused to help toilet the resident on an identified date because they were going on break. An interview with PSW #133 was not possible as they were on an extended leave of absence.

During an interview with Administrator #113, they acknowledged that the home failed to ensure that resident #027 was free from neglect by the staff in the home.

The severity of this non-compliance was identified as actual harm or risk, the scope was identified as pattern. Review of the home's compliance history revealed unrelated non-compliance. Due to the severity of actual harm or risk and the scope was pattern a compliance order is warranted. (649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 05, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 2nd day of November, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JulieAnn Hing

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