



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

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

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4^{ième} étage
OTTAWA ON L1K 0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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

Amended Public Copy/Copie modifiée du public de permis

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ Registre no | Type of Inspection / Genre d'inspection |
|---|---|-------------------------------|--|
| Feb 05, 2015; | 2014_198117_0023 (A1) (Appeal\Dir#: Appeal/Dir#: DR#34) | O-000804-14 | Complaint |

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

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

CARESSANT CARE BOURGET
2279 Laval Street P.O. Box 99 Bourget ON K0A 1E0

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



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

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

LYNE DUCHESNE (117) - (A2)(Appeal\Dir#: Appeal/Dir#: DR#34)

Amended Inspection Summary/Résumé de l'inspection modifié

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order. The Director's review was completed on Jan. 14, 2015. The Order was revised to reflect the Director's review. The Director's order is attached to this report.

Issued on this 5 day of February 2015 (A2)(Appeal\Dir#: Appeal/Dir#: DR#34)

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

Original report signed by the inspector.



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

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

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4^{ième} étage
OTTAWA ON L1K 0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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

Amended Public Copy/Copie modifiée du public de permis

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|--------------------------------|--|
| Feb 05, 2015; | 2014_198117_0023 (A1) (Appeal/Dir# Appeal/Dir#: DR#34) | O-000804-14 | Complaint |

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

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

CARESSANT CARE BOURGET
2279 Laval Street P.O. Box 99 Bourget ON K0A 1E0

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



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

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

LYNE DUCHESNE (117) - (A2)(Appeal/Dir# Appeal/Dir#: DR#34)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 22, 25 & 26 as well as September 5, 8, 9 and 10, 2014

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Caressant Care Regional Manager/Nurse Consultant, several Registered Nurses (RN), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), the home's maintenance man, a maintenance man from another Caressant Care home, a housekeeper and to several residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Critical Incident Response

Falls Prevention

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Responsive Behaviours

Safe and Secure Home

Sufficient Staffing



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

- 4 WN(s)
- 3 VPC(s)
- 1 CO(s)
- 0 DR(s)
- 0 WAO(s)

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|--|
| Legend | Legendé |
| WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order | WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités |
| Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) | 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. |
| The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator



Specifically failed to comply with the following:

- s. 212. (4) Subject to subsection (5), the licensee shall ensure that everyone hired as an Administrator after the coming into force of this section,**
- (a) has a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration; O. Reg. 79/10, s. 212 (4).**
 - (b) has at least three years working experience,**
 - (i) in a managerial or supervisory capacity in the health or social services sector, or**
 - (ii) in another managerial or supervisory capacity, if he or she has already successfully completed the course mentioned in clause (d); O. Reg. 79/10, s. 212 (4).**
 - (c) has demonstrated leadership and communications skills; and O. Reg. 79/10, s. 212 (4).**
 - (d) has successfully completed or, subject to subsection (6), is enrolled in, a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time. O. Reg. 79/10, s. 212 (4).**

Findings/Faits saillants :



1. The licensee has failed to ensure that the home's administrator has a post-secondary diploma in health or social services from a program that is a minimum of two years duration.

The home's current administrator was hired in June 2014. His qualifications were reviewed as part of this inspection. On August 22, 2014, the Administrator provided a copy of his Curriculum Vitae to Inspector #133. The Caressant Care Regional Manager/Nurse Consultant was also present on August 22, 2014 and stated to Inspector #133 that Caressant Care Corporation had verified the Administrators educational diplomas and certifications.

It is noted that the Administrator has the Ontario Long Term Care Administrator Recognition from the Ontario Long Term Care Association (OLTCA) (January 2010), has over 3 years working experience in a managerial or supervisory capacity, is fully bilingual and has demonstrated leadership and communication skills. The Administrator is in the process of completing the Administrator Course through the Canadian Healthcare Association (CHA). The Administrator also has a diploma in Hotel and Restaurant Management from La Cité Collégiale. This diploma is from a hotel/restaurant management program and not from a health or social services program from a recognized post-secondary institution.

As per the regulations, any administrator hired after the coming into force of this legislation must meet the following requirements: (a) has a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration.

The home's administrator does not have a post-secondary diploma in health or social services from a program and therefore does not meet the hiring requirements for the position of administrator in a long-term care home. [s. 212. (4)]

Additional Required Actions:

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



(A2)(Appeal/Dir# DR# 034)

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

**WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:**

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's written plan of care set out the planned care for Resident #3 as it relates to responsive behaviours as well as for Resident #1 as it relates to personal care preferences.

1) Resident #3 is identified as having cognitive impairments. Staff members S#101 and PSW S#107 stated to Inspector #117 on September 9, 2014, that Resident #3 has some social disinhibitions in which he/she will seek out the company of male/female residents, hold hands and try to give kisses on their cheeks. The resident's attending physician confirmed to the Inspector that Resident #3 has been demonstrating these behaviours for the past few months and that nursing staff are monitoring the resident's behaviours and redirecting the resident away from male/female residents as needed.

A review of Resident #3's current plan of care was conducted. The plan of care does identify that the resident has cognitive impairments. The plan does not identify the resident's social disinhibitions and it does not identify the staff interventions in place to redirect the resident when he/she becomes socially disinhibited. Resident #3's written plan of care does not identify the resident's responsive behaviours and staff interventions. [s. 6. (1) (a)]

2. Resident #1 has rheumatoid arthritis which limits his/her ability to do various activities of daily living. The resident requires extensive assistance of one person to



help with personal care and dressing. On September 5, 2014, Resident #1 stated to Inspector #117 that he/she does not want any male staff member to assist with the provision of his/her personal care. The resident stated that no male staff member has ever assisted with his/her personal care needs, and confirmed that only female staff members have provided assistance with his/her personal care.

Inspector #117 spoke with staff members, S#105 and S#109 on September 5, 2014 and staff member S#113 and S#104 on September 8, 2014. All staff members stated that they are aware that Resident #1 does not want any male staff member to assist with the provision of his/her personal care. The home's Director of Care and Administrator also stated that they are aware of Resident #1's wish not to have any male staff member assist with his/her personal care. A review of Resident #1's current plan of care was conducted. The plan does identify that Resident #1 requires extensive assistance with dressing and personal care. However it does not specify that the resident does not want any male staff member to provide assistance with personal care and dressing. Resident #1's written plan of care does not identify the resident's personal care preferences. [s. 6. (1) (a)]

3. Resident #1 is a very private person who informed the home that he/she does not want any other resident to enter and or wander into his/her room. Resident #1 becomes upset and agitated when other residents enter his/her room. A curtain, which is kept partially open, and a yellow wanderguard band were applied to the entrance of the resident's room door to redirect wandering residents from entering Resident #1's room. The yellow band has been in place at the resident's room entrance since September 2013. The curtain has been in place for more than 1 year as per Resident #1 and nursing staff.

On a specified day in June 2014, Resident #2 entered Resident #1's room. Resident #2 walked through the yellow wanderguard band, went to Resident #1's bedside and hit with his/her hands Resident #1's elevated hands. Resident #1 rang the call bell and called out for help. PSW S#112 and then RN S#103 arrived in the room. They found Resident #2 standing at the end of Resident #1's bed, the yellow wanderguard band in his/her hands. Resident #1 was very upset by the incident. Resident #2 was redirected out of the room and Resident #1 was assessed by the RN, no injuries were noted. Both residents' families, attending physician, the home's Director of Care and the local police services were notified of the incident.

Resident #1's POA requested that the home look at an alternative barrier to the yellow



band to prevent other residents, including Resident #2 from entering Resident #1's room.

Eleven days later, the home's Administrator informed Resident #1's POA that a baby gate was installed at the entrance of Resident #1's door. The yellow wanderguard band was also applied on top of the baby gate. The door curtain remained in place. Email correspondence dated that same day, shows Resident #1's POA giving consent for the use of the baby gate as a barrier to prevent other residents from entering into Resident #1's room.

Resident #1's plan of care, dated August 22, 2014, was reviewed. It does indicate that Resident #1 has feelings of uneasiness and anger related to wandering co-residents entering his/her room. The plan identifies that the yellow wanderguard band at the room entrance was implemented in September 2013. The plan does not identify when the curtain at the resident's room door, to act as a visual barrier, was implemented. The resident's plan of care was not updated on a specified day in June 2014 to reflect the implementation of a baby gate as a barrier to prevent other residents from entering Resident #1's room. The plan of care was not updated until August 25 2014 by the home's administrator when Inspector #133 requested a copy of the plan of care.

Resident #1's written plan of care does not set out the resident's plan of care related to the use of curtain and baby gate. [s. 6. (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 the written plan of care for Resident #3 sets out the planned care related to social disinhibitions and that the written plan of care for Resident #1 sets out the planned care related to the provision of personal care, use of wanderguard banners, curtains and baby gate, to be implemented voluntarily.



**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. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 15 (2) (a) in that the licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

On August 25th, 2014, in the identified areas, Inspector #133 observed the following:

Bedroom #201:

3 of the privacy curtains in this bedroom were noted to be stained and dirty with dried matter of various colours.

It is to be noted that this bedroom received an enhanced cleaning on August 26th, 2014, and these dirty privacy curtains remained in place. The inspector was informed by a housekeeper, Staff #S100 that there are no extra privacy curtains at the home, so if they take them down, the residents will not have any privacy in their bed space until the curtains can be washed, dried and rehung.

Bedroom #204:

In the bathroom, lingering urine odors have been addressed in a finding of non-compliance elsewhere within this inspection report.

The wall behind and around the toilet was dirty with dried brown spots.

Within this bedroom, the table next to a resident's comfortable easy chair was dirty



with an old blackened banana peel, and there were fruit flies around it. There was spilt juice dried on the table, as well as on the floor behind the table. The Director of Care entered the bedroom just after the inspector observed this, and removed the banana peel.

Bedroom #205:

The bathroom exhaust vent was dirty with accumulated dust.

Within the bedroom, next to Resident #001's bed, the wall was dirty with spots of dried brown matter.

The top of the heat register was dirty with accumulated dust and debris.

The wall to the left of the bathroom was also dirty with spots of dried brown matter, most pronounced in the area under the clock, behind the blue rocking chair.

The blue rocking chair was dirty with accumulated debris in the seams.

On August 26th, 2014, this bedroom received an "enhanced" cleaning. The inspector noted that the areas of concern noted on the 25th remained unchanged. These areas of concern were shown to the Administrator on the 26th.

Bedroom #207:

The top of the freestanding closet was dirty with accumulated dust.

The top of the baseboard heat register was dirty with accumulated dust.

On August 26th, 2014, in the identified areas, Inspector #133 observed the following:

Bedroom #208:

The top of the freestanding closet was dirty with accumulated dust.

The wall around the perimeter of the bedroom was dirty with spots of dried matter of varying colours, most pronounced in the area of the hand sanitizer dispenser around to the bed, and closer to the entrance of the bedroom, in the area of the activity calendar and electrical outlet.



Under the bed, in the area of the headboard, there was an accumulation of debris.

The floor was dirty with darkened sticky spots, most pronounced in the area of the hand sanitizer dispenser, and around to the bed.

Bedroom #209:

The bathroom wall at the baseboard heat register was dirty with spots of dried dark coloured matter.

Within the bedroom, the wall to the right, immediately upon entry, was dirty with spots of dried matter of various colour. This was most pronounced in the corner.

Bedroom #211:

The wall to the left, immediately upon entry into the bedroom, was dirty with spots of dried matter. The top of the freestanding closet was dirty with accumulated dust.

Bedroom #214:

The outside of the bedroom door, lower area, was dirty with spots of dried and sticky brown matter.

In the bathroom, the wall to the left of the toilet, and behind the toilet, to the right, was dirty with spots of dried brown matter.

The top of the freestanding closet within the bedroom was dirty with accumulated dust.

The baseboard heat register, towards the center, was dirty with sticky brown matter, and the top of the register was dirty with accumulated dust and debris.

Bedroom #212:

In the bathroom, the wall behind the toilet, to the left, and wrapping around under the sink, was dirty with dark coloured spots. As well, the outer front face of the toilet bowl was dirty in areas with dried feces. This was shown to the Administrator on that date.



The outer bathroom door, left side, and the wall to the immediate left were dirty with dark coloured spots.

Within the bedroom, the top of the freestanding closet and the items on it were dirty with accumulated dust, as were the items on the dresser.

The outer bedroom door was dirty with spots of dried brown matter.

Bedroom #210:

The wall to the left of the toilet, under the toilet paper dispenser, was dirty with dried light coloured spots and drips.

Under the bed, in the area of the headboard, there was an accumulation of debris.

Bedroom #215:

The outer lower bathroom door was dirty with spots of dried brown matter.

Bedroom #206:

The top of the baseboard heat register was dirty with accumulated dust and debris.

2nd floor dining room:

Most of the curtains were noted to be stained and dirty with dried matter, typically in the lower area of the curtain. Due to how the curtains hang, this is most notable when the curtains are pulled outwards, as the soiling is obscured within the folds.

At the handsink, there was an accumulation of thick pink residue around the taps. The wall above the sink, and around the eye wash station, was dirty with dried spots. The lower wall in the area of the hand sanitizer dispenser was dirty with dried spots. The lid of the linen receptacle was dirty with accumulated food debris. The wall to the left of the fridge was dirty with dried matter. The wall between the first two sets of windows was dirty with dried matter (closest to the fridge). The wall under the 2nd set of windows was dirty with dried light coloured matter. The wall to the right of the next set of windows was dirty with dried matter. At the last table, on the side of the dining room overlooking the street, the lower wall and top of the baseboard heater was dirty with dried light brown matter.



Room #224 (Clean utility): The outer door was dirty with dried brown spots and drips.

Room #223 (Med Room): The outer lower door was dirty with dried dark matter. [s. 15. (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 the identified areas and curtains are kept clean and sanitary, to be implemented voluntarily.

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87.
Housekeeping**

Specifically failed to comply with the following:

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

Findings/Faits saillants :



1. The licensee has failed to comply with O. Reg. 79/10, s. 87 (2)(d) in that the home has failed to address lingering offensive odours in a resident washroom. Despite routine cleaning, lingering offensive odours remain in resident washroom #204.

On August 25, 2014, at 12:21pm, the inspector noted a strong urine odor upon entry into bedroom #204. The inspector opened the bathroom door, and observed a towel on the floor around the base of the toilet, which appeared to be soaked with urine. The raised toilet seat on the toilet was stained and dirty. When the inspector took the raised seat off the toilet, it was observed that the underside was stained and dirty. As well, there was a small accumulation of corroded metal debris on either side of the lip of the toilet bowl, in the area of the screws that hold the raised seat arms in place, and the lip of the toilet bowl at the front was dirty. This was brought to the attention of the Administrator and the Director of Care. The inspector returned to bedroom #204 at 1:37pm. The bathroom had been cleaned, there was no urine in the toilet, yet a lingering urine odour remained. The floor tiles around the toilet were discoloured, and was the grouting.

On August 26, 2014, at 10:20am, the inspector detected a urine odor emanating from bedroom # 204, from the hallway. There was a length of paper towel on the floor, next to the toilet, with fecal matter on it. The raised toilet seat was dirty in areas with dried feces. A housekeeper working in the immediate area informed the inspector that this bathroom had not yet been cleaned. The inspector returned to bedroom #204 at 1:16pm. The bathroom had been cleaned, there was no urine in the toilet, yet the lingering urine odour remained.

It is noted that in the bathroom, to the left of the toilet, on the floor, the inspector observed a small canister of an odor absorbing product. This intervention was not effective in addressing the lingering urine odor.

The Licensee has a history of non-compliance related to lingering offensive odors. As a result of follow up inspection #2012_054133_0035, that was conducted on August 28th, 2012, the licensee was issued a Written Notification with the additional required action of a Voluntary Plan of Correction, related to 3 resident bathroom, including #204. [s. 87. (2) (d)]

Additional Required Actions:



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

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

***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 offensive odours in resident washroom
#204 are addressed, to be implemented voluntarily.***



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

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

Issued on this 5 day of February 2015 (A2)(Appeal/Dir# Appeal/Dir#: DR#34)

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

Original report signed by the inspector.



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, L1K-0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4^{ième} étage
OTTAWA, ON, L1K-0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : LYNE DUCHESNE (117) - (A2)(Appeal/Dir#
Appeal/Dir#: DR#34)

Inspection No. /

No de l'inspection : 2014_198117_0023 (A2)(Appeal/Dir# Appeal/Dir#:
DR#34)

Appeal/Dir# /

Appel/Dir#: Appeal/Dir#: DR#34 (A2)

Log No. /

Registre no. : O-000804-14 (A2)(Appeal/Dir# Appeal/Dir#: DR#34)

Type of Inspection /

Genre d'inspection: Complaint

Report Date(s) /

Date(s) du Rapport : Feb 05, 2015;(A2)(Appeal/Dir# Appeal/Dir#: DR#34)

Licensee /

Titulaire de permis : CARESSANT-CARE NURSING AND RETIREMENT
HOMES LIMITED
264 NORWICH AVENUE, WOODSTOCK, ON, N4S-
3V9

LTC Home /

Foyer de SLD : CARESSANT CARE BOURGET
2279 Laval Street, P.O. Box 99, Bourget, ON, K0A-
1E0



Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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

Steve Golden

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

(A2)(Appeal/Dir# DR# 034)

The following Order has been rescinded:

Order # /

Ordre no : 001

Order Type /

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 212. (4) Subject to subsection (5), the licensee shall ensure that everyone hired as an Administrator after the coming into force of this section,

(a) has a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration;

(b) has at least three years working experience,

(i) in a managerial or supervisory capacity in the health or social services sector, or

(ii) in another managerial or supervisory capacity, if he or she has already successfully completed the course mentioned in clause (d);

(c) has demonstrated leadership and communications skills; and

(d) has successfully completed or, subject to subsection (6), is enrolled in, a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time. O. Reg. 79/10, s. 212 (4).



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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

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

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

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

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

Issued on this 5 day of February 2015 (A2)

**Signature of Inspector /
Signature de l'inspecteur :**

**Name of Inspector /
Nom de l'inspecteur :**

Mary Nestor (Director) - (A2)(Appeal/Dir#
Appeal/Dir#: DR#34)

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

Ottawa



Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

| | |
|---|--|
| | <input type="checkbox"/> Licensee Copy/Copie du Titulaire <input checked="" type="checkbox"/> Public Copy/Copie Public |
| Name of Director: | |
| Order Type: | <input type="checkbox"/> Amend or Impose Conditions on Licence Order, section 104 <input type="checkbox"/> Renovation of Municipal Home Order, section 135 <input checked="" type="checkbox"/> Compliance Order, section 153 <input type="checkbox"/> Work and Activity Order, section 154 <input type="checkbox"/> Return of Funding Order, section 155 <input type="checkbox"/> Mandatory Management Order, section 156 <input type="checkbox"/> Revocation of Licence Order, section 157 <input type="checkbox"/> Interim Manager Order, section 157 |
| Intake Log # of original inspection (if applicable): | O-000804-14 |
| Original Inspection #: | 2014_198117_0023 |
| Licensee: | Caressant Care Nursing and Retirement Homes Limited |
| LTC Home: | Caressant Care Bourget Long-Term Care Home |
| Name of Administrator: | Steven Golden |

| | |
|--|--|
| Background: | |
| <p>Ministry of Health and Long-Term Care (MOHLTC) Inspectors #117 and #133 conducted an inspection of Caressant Care Bourget Long-Term Care Home (the Home), in Bourget, ON, on August 22, 25, 26 and September 5, 8, 9, 10, 2014. The purpose of the visit was to conduct a Complaint inspection. During the inspection the Inspector found that the Licensee, Caressant Care Nursing and Retirement Homes Limited (CC Bourget or the Licensee), failed to comply with certain provisions of the <i>Long-Term Care Homes Act, 2007</i> (LTCHA) and Ontario Regulation 79/10 (Regulation). Pursuant to s.153 (1)(a) of the LTCHA, the Inspector #117 issued the following:</p> <ul style="list-style-type: none"> ▪ Compliance Order #001 (Order #001) relates to LTCHA, 2007, Ontario Regulation 79/10, s.212 (4) and reads as follows: “The Licensee shall refrain from employing an Administrator of Caressant Care Bourget, unless and until the person has either a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration. The Licensee is to provide the current incumbent with the support of a qualified administrator | |

though the implementation of a set of detailed, comprehensive strategies until compliance is achieved.”

The Licensee made a timely request for a Director Review of Order #001. The Licensee requested that the Director alter the Order.

Based on a review of the facts, the Director concluded that an Order is appropriate to address the non-compliance with s. 212(4) of the Regulation. The original inspector’s order # 001, issued by Inspector #117 and served on the Licensee on November 26, 2014 is however altered to extend the compliance date to August 31, 2016.

The altered Compliance Order is as follows:

The Licensee shall refrain from employing an Administrator of Caressant Care Bourget, unless and until the person has either obtained a post-secondary degree from a program that is a minimum of three years duration, or a post-secondary diploma in health and social services from a program that is minimum of two years in duration.

Compliance date: August 31, 2016

Additionally, the Director issued a new Order, pursuant to s.153 (1)(b) of the LTCHA , as indicated below.

Order:

Order Type: Compliance Order, s. 153 (1) (b)

To **Caressant Care Nursing and Retirement Homes Limited**, you are hereby required to comply with the following order by the date(s) set out below:

Pursuant to: O Reg 79/10, s. 212(4)

Order:

The Licensee shall prepare, submit and implement a plan to ensure that the Administrator has access to a qualified Administrator to provide support in their role as Administrator of Caressant Care Bourget Long-Term Care Home until the earlier of the date, that is they obtain a post-secondary diploma in health or social services from a program that is a minimum of two years in duration as required by s. 212(4)(a) of O Reg 79/10 or August 31, 2016.

LTCHA 2007, SO 2007, c 8, O Reg 79/10 s. 212(4)

Plan to be submitted to: Inspector Lyne Duchesne, at Ottawa Service Area Office, 347 Preston St., 4th Floor, Ottawa, ON K1S 3J4, or electronically to: Lyne.Duchesne@ontario.ca

Grounds:

As indicated in the inspector’s order there is non-compliance with Ontario Regulation 79/10, s.212 and an Order is reasonable. By granting the extension of the inspector’s compliance date, the non-compliance will continue until such time as the Administrator obtains the requisite diploma as they will continue to be the



Ministry of Health and Long-Term Care

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée

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

| | |
|--|---|
| <p>Administrator for the Home.</p> <p>However, to mitigate the risk of having the Administrator continue in the role while they are obtaining the diploma, the Administrator should have the support of a qualified Administrator to assist through this period. In addition, the Ministry will monitor the home through its inspection program, hence this order.</p> | |
| <p>This order must be complied with by:</p> | <p>Plan to be submitted by: no later than January 30, 2015</p> <p>Plan to be implemented by: February 6, 2015</p> |

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

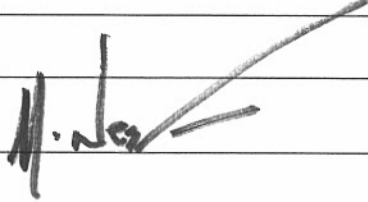
The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
1075 Bay St., 11th Floor, Suite 1100
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.

| | |
|---|--|
| Issued on this 15th day of January, 2015. | |
| Signature of Director: |  |
| Name of Director: | Mary Nestor |