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 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 sions de longue durée

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 31, 2016	2016_328571_0023	007732-16, 012778-16, 018714-16	Critical Incident System

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 LINDSAY NURSING HOME
240 MARY STREET WEST LINDSAY ON K9V 5K5

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

PATRICIA MATA (571)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 8, 9, 10, 11, 12, 15, 16, 2016

The following Critical Incident Logs were inspected:
012778-16 re: injury resulting in a change in condition; 018714-16 re: resident to resident abuse; and 007732-16 re: staff to resident verbal abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Resident Care Co-ordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Physiotherapist, and resident's.

In addition, the following were reviewed: clinical records, policies, manuals, and administrative documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

Re: Log # 012778-16:

A Critical Incident (CI) was submitted to the Director for resident #011 who sustained an injury.

A review of the clinical record indicated that resident #011 had an existing medical concern at the time of the injury. A review of the licensee's electronic records indicated the existing medical condition worsened over a specified five month period. In addition, resident #011 developed an additional medical concern after the injury which also worsened over a specified three month period.

A review of the Physician orders indicated the treatment for the existing medical concern

remained consistent over a five month period despite the worsening condition and the new medical problem was treated in the same manner for a two month period despite it also worsening.

After the five and two month period when both medical conditions had worsened, resident #011 was referred to a specialist for treatment. A review of a referral letter dated a specified date indicated a surgical intervention was necessary to resolve both medical issues of resident #011's as they had worsened to the point that treatment would not be effective.

The Resident Care Coordinator (RCC) indicated in an interview on a specified date that special equipment to possibly prevent worsening of both medical issues and provide comfort had not been ordered and initiated until a specified date after both medical conditions had worsened and could no longer be cured.

The Acting Director of Care indicated in an interview on August 16, 2016, that the home has a committee for the specified medical condition. This committee was required to meet every second month but as of August 16, 2016, the committee had not met yet in 2016.

To summarize, the nursing team on the unit where resident #011 resides were not consistent with their assessments of the resident's medical condition. In addition, despite resident #011's two specified medical conditions worsening, a referral to a specialist was not made nor was special equipment initiated until the both specified medical conditions had worsened considerably.

Therefore, the licensee failed to ensure that the staff and others involved in the different aspects of care of resident #011 collaborated with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and (b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. [s. 6. (4) (a)]

2. The licensee failed to ensure that the plan of care was reviewed and revised when the care needs of a resident changed.

Resident #011 developed an infection on a specified date:

-on a specified date and time- RPN #115 documents at that the resident #011 was displaying specified signs and symptoms of a specified infection -she informs RN #114
-on a specified date and time- RN #114 documents that she will ask the next shift to follow up with the Doctor
-on a specified date and time- RN #114 documents that resident #011 had approached her complaining of pain and crying- the resident was displaying specified signs and symptoms of infection and RN #114 would have the day RN follow up
-on a specified date and time- RN #116 documents that the resident's signs and symptoms of infection are worsening –RN #116 will pass this on to day staff to call the Doctor for an antibiotic order
-on a specified date and time- RN #116 documents that the resident signs and symptoms of infection are much worse and the resident has increased pain –RN #116 will advise the Day Charge Nurse to call the Doctor for an antibiotic order
-on a specified date and time- RN #113 documents that the resident was seen by the Doctor and new orders received for infection

To summarize, the resident displayed signs and symptoms of infection on a specified date. Despite the signs and symptoms worsening and increase pain, the resident did not receive treatment until four days later.

Therefore, the licensee failed to ensure that the plan of care for resident #011 was reviewed and revised when resident #011's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe positioning devices when assisting a resident.

Re: Critical Incident (CI) Log #012778-16:

A critical incident was submitted to the Director for incident resulting in injury. The CI indicated that resident #011 was being readied for a bath. PSW #110 transferred resident #011 from a mobility aid to a tub chair. Once the resident was in the tub chair PSW #110 attempted to put the seat belt on but the resident refused. A bar on the tub chair that is lowered so it is in front of the resident was also not engaged. While the PSW was moving the mobility aid out of the way, resident #011 leaned forward and fell off of the tub chair. The resident #011 sustained an injury. Resident #011 was transferred to the hospital for assessment. The resident returned to the home after treatment.

In an interview on August 10, 2016, PSW #110 indicated that he/she transferred resident #011 from the mobility aid to the tub chair. The PSW moved to the side of the tub chair to apply the brakes. The resident leaned forward and fell forward and sustained a specified injury. PSW #011 indicated that he/she did not have a chance to apply the seat belt or to put the bar down on the tub chair. PSW #110 indicated he/she always puts the bar down but only applies the seat belt sometimes if the resident agrees.

A review of the licensee's "Safe Lifting and Transfers Training" booklet indicates that it is the responsibility of staff to use equipment properly. A review of the "Alenti Educational Training and Highlights" dated August 2006 provided by the licensee includes a warning that the seat belt must be used at all times and the resident must be able to understand and respond to instructions to stay seated in an upright position.

Therefore, the licensee failed to ensure that PSW #110 used safe positioning techniques when assisting resident #011 in the tub chair. [s. 36.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate actions were taken in response to any medication incident involving a resident.

Re: Critical Incident Log # 012778-16:

A review of the clinical record indicated that resident #011's had a specified medical diagnosis. A review of the Physician Orders for a specified date indicated that the resident was to receive a specific medication three times daily if necessary. In addition, the resident received another specified medication at bedtime.
A review of a specified policy effective July, 2010 indicated that if a resident is experiencing a specified adverse medical condition, the licensee is to provide specific medical interventions and inform the physician.
A review of the clinical records for resident #011 indicated the resident experienced an adverse medical condition on eight specified dates in a specified month. Documentation for treatment of this condition could only be found on two specified dates. On a specified date, after eight days of resident #011 experiencing the specified adverse medical condition, the physician was notified and orders were received to adjust resident #011's medication.
After, resident #011's medication was adjusted; the resident experienced an adverse medical condition on nine additional days. Documentation regarding treatment for this

adverse condition could only be found on one of those days. On a specified date, nine days after the resident experienced the adverse medical condition, the physician is notified and again adjusts the resident's medication.

After, resident #011's medication is once again adjusted; the resident experiences an adverse medical condition on five additional days. Documentation regarding treatment for this adverse condition could only be found on one of those days. On a specified date, five days after the resident experienced the adverse medical condition; the physician is notified and once again adjusts the resident's medication.
After, resident #011's medication is adjusted; the resident experiences an adverse medical condition on eight additional days for a specified month. No evidence of documentation of neither treatment of the adverse medical condition nor notification of the physician could be found.

RPN #117 indicated in an interview on August 16, 2016 at 1411 hrs that resident #011 does experience an adverse medical condition and the RPN would wait not more than four days to notify the physician.

Therefore, the licensee failed to ensure that appropriate actions were taken in response to any medication incident involving a resident #011. [s. 134. (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 with ensuring that appropriate actions are taken in response to any medication incident involving a resident, including documentation of actions,, 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).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

Re: Log # 012778-16:

A Critical Incident (CI) #2701-000012-16 was submitted to the Director after resident #011 sustained an injury.

A review of the clinical record indicated that resident #011 had an existing medical concern at the time of the injury. A review of the licensee's electronic records indicated the existing medical condition worsened over a specified five month period. In addition, resident #011 developed an additional medical concern after the injury which also worsened over a specified three month period.

A review of the Physician orders indicated the treatment for the existing medical concern remained consistent over a five month period despite the worsening condition and the new medical problem was treated in the same manner for a two month period despite it also worsening.

After the five and two month period when both medical conditions had worsened, Resident #011 was referred to a specialist for treatment. A review of a referral letter dated a specified date indicated a surgical intervention was necessary to resolve both medical issues of resident #011's as they had worsened to the point that treatment would not be effective.

The Resident Care Coordinator (RCC) indicated in an interview on a specified date that special equipment to possibly prevent worsening of both medical issues and provide comfort had not been ordered and initiated until a specified date after both medical conditions had worsened and could no longer be cured.

The Acting Director of Care indicated in an interview on August 16, 2016, that the home has a committee for the specified medical condition. This committee was required to meet every second month but as of August 16, 2016, the committee had not met yet in 2016.

To summarize, the nursing team on the unit where resident #011 resides were not consistent with their assessments of the resident’s medical condition. In addition, despite resident #011’s two specified medical conditions worsening, a referral to a specialist was not made nor was special equipment initiated until the both specified medical conditions had worsened considerably.

Therefore, the licensee failed to ensure for resident #011 who had two worsening pressure ulcers receives interventions to reduce or relieve pain, promote healing, and prevent infection. [s. 50. (2) (b) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that for a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the resident receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, to be implemented voluntarily.

Issued on this 28th day of November, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére 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 sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PATRICIA MATA (571)
Inspection No. / No de l'inspection :	2016_328571_0023
Log No. / Registre no:	007732-16, 012778-16, 018714-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 31, 2016
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 LINDSAY NURSING HOME 240 MARY STREET WEST, LINDSAY, ON, K9V-5K5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Butch Ashcroft

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:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is ordered to develop and implement a process that ensures:
-staff involved in the care of residents with a specified medical condition,collaborate with each other in the assessment of the residents and in the development and implementation of the plan of care related to the specified medical condition so that their assessments and different aspects of care are integrated, consistent and complement each other;
-the results of specified assessments and their progress are monitored by the Director of Care or designate and changes are communicated to members of the multidisciplinary team in a timely manner

Grounds / Motifs :

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

Re: Log # 012778-16:

A Critical Incident (CI) was submitted to the Director for resident #011 who

sustained an injury.

A review of the clinical record indicated that resident #011 had an existing medical concern at the time of the injury. A review of the licensee's electronic records indicated the existing medical condition worsened over a specified five month period. In addition, resident #011 developed an additional medical concern after the injury which also worsened over a specified three month period.

A review of the Physician orders indicated the treatment for the existing medical concern remained consistent over a five month period despite the worsening condition and the new medical problem was treated in the same manner for a two month period despite it also worsening.

After the five and two month period when both medical conditions had worsened, resident #011 was referred to a specialist for treatment. A review of a referral letter dated a specified date indicated a surgical intervention was necessary to resolve both medical issues of resident #011's as they had worsened to the point that treatment would not be effective.

The Resident Care Coordinator (RCC) indicated in an interview on a specified date that special equipment to possibly prevent worsening of both medical issues and provide comfort had not been ordered and initiated until a specified date after both medical conditions had worsened and could no longer be cured.

The Acting Director of Care indicated in an interview on August 16, 2016, that the home has a committee for the specified medical condition. This committee was required to meet every second month but as of August 16, 2016, the committee had not met yet in 2016.

To summarize, the nursing team on the unit where resident #011 resides were not consistent with their assessments of the resident's medical condition. In addition, despite resident #011's two specified medical conditions worsening, a referral to a specialist was not made nor was special equipment initiated until the both specified medical conditions had worsened considerably.

Therefore, the licensee failed to ensure that the staff and others involved in the different aspects of care of resident #011 collaborated with each other, (a) in the assessment of the resident so that their assessments are integrated and are

consistent with and complement each other; and (b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. [s. 6. (4) (a)]

(571)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 21, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is ordered to develop and implement a process that ensures:
-when a resident's care needs change related to a specified condition , the plan of care is reviewed and revised
-changes in resident's condition related to a specified medical condition are communicated between shifts

Grounds / Motifs :

1. The licensee failed to ensure that the plan of care was reviewed and revised when the care needs of a resident changed.

Resident #011 developed an infection on a specified date:

-on a specified date and time- RPN #115 documents at that the resident #011 was displaying specified signs and symptoms of a specified infection -she informs RN #114
-on a specified date and time- RN #114 documents that she will ask the next shift to follow up with the Doctor
-on a specified date and time- RN #114 documents that resident #011 had approached her complaining of pain and crying- the resident was displaying specified signs and symptoms of infection and RN #114 would have the day RN follow up
-on a specified date and time- RN #116 documents that the resident's signs and symptoms of infection are worsening –RN #116 will pass this on to day staff to call the Doctor for an antibiotic order
-on a specified date and time- RN #116 documents that the resident signs and symptoms of infection are much worse and the resident has increased pain –RN #116 will advise the Day Charge Nurse to call the Doctor for an antibiotic order
-on a specified date and time- RN #113 documents that the resident was seen by the Doctor and new orders received for infection

To summarize, the resident displayed signs and symptoms of infection on a specified date. Despite the signs and symptoms worsening and increase pain, the resident did not receive treatment until four days later.

Therefore, the licensee failed to ensure that the plan of care for resident #011 was reviewed and revised when resident #011's care needs changed. [s. 6. (10) (b)]

(571)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 21, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall re-educate all nursing staff regarding safe use of the Arjo Alenti Lift and Hygiene chair including all alerts issued by Arjo for this chair. This education should delivered in a classroom setting with demonstration of equipment and should include a component to show that staff have an understanding of how to use the equipment and risks involved.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe positioning devices when assisting a resident.

Re: Critical Incident (CI) Log #012778-16:

A critical incident was submitted to the Director for incident resulting in injury. The CI indicated that resident #011 was being readied for a bath. PSW #110 transferred resident #011 from a mobility aid to a tub chair. Once the resident was in the tub chair PSW #110 attempted to put the seat belt on but the resident refused. A bar on the tub chair that is lowered so it is in front of the resident was also not engaged. While the PSW was moving the mobility aid out of the way, resident #011 leaned forward and fell off of the tub chair. The resident #011 sustained an injury. Resident #011 was transferred to the hospital for assessment. The resident returned to the home after treatment.

In an interview on August 10, 2016, PSW #110 indicated that he/she transferred resident #011 from the mobility aid to the tub chair. The PSW moved to the side of the tub chair to apply the brakes. The resident leaned forward and fell forward and sustained a specified injury. PSW #011 indicated that he/she did not have a chance to apply the seat belt or to put the bar down on the tub chair. PSW #110

indicated he/she always puts the bar down but only applies the seat belt sometimes if the resident agrees.

A review of the licensee's "Safe Lifting and Transfers Training" booklet indicates that it is the responsibility of staff to use equipment properly. A review of the "Alenti Educational Training and Highlights" dated August 2006 provided by the licensee includes a warning that the seat belt must be used at all times and the resident must be able to understand and respond to instructions to stay seated in an upright position.

Therefore, the licensee failed to ensure that PSW #110 used safe positioning techniques when assisting resident #011 in the tub chair. [s. 36.]

An order was issued due to the severity and history of the non-compliance found in relation to safe transferring and positioning devices or techniques. Resident #011 was actually harmed when a bath chair was used incorrectly and resulted in a specified injury. Also, a review of the compliance history of the licensee indicated that on December 16, 2015, Inspection # 2015_360111_0028, a Voluntary Plan of Correction (VPC) was issued for unsafe transferring and positioning techniques or devices that resulted in an injury to another resident.

In addition, the non-compliance found in this report related to unsafe transfers and positioning techniques and devices, caused resident #011 to sustain a specified injury which caused a significant change in the resident's condition. As a result of the significant change in condition, resident #011 suffered serious consequences when his/her plan of care related to wounds was not based on a collaboration of the multidisciplinary team and when the plan of care was not reviewed and revised related to an infection. Also, under written notification (WN) #3 in the licensee report, a VPC has been issued related to non-compliance with wound care for resident #011. Therefore, two orders were issued related to plan of care based on the severity of the consequences of the non-compliance.

(571)

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

Ministére 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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 30, 2016

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

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

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

RENSEIGNEMENTS 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, ON
M5S-2B1
Fax: 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 31st day of October, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Patricia Mata

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