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 soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 24, 25, 2017	2016_303563_0042	033550-16	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 WOODSTOCK NURSING HOME
81 FYFE AVENUE WOODSTOCK ON N4S 8Y2

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

MELANIE NORTHEY (563), SHERRI COOK (633)

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): December 2, 5, 6, 7, 8, 12, 13, 15, 19 and 20, 2016 and January 4, 5, 6, 9, 10, 11, 12, 13 and 16, 2017

During the course of the inspection, the inspector(s) spoke with the Vice President of Operations, the acting Administrator, the Director of Nursing, the Registered Nurse Consultant, the Activity Coordinator, the Registered Nurse Resident Assessment Instrument Coordinator, the Registered Practical Nurse Resident Assessment Instrument Coordinator, the Registered Practical Nurse Behavioural Supports Ontario, the Corporate Dietitian, the Dietary Services Consultant, the Physiotherapist, a Physio Aide, the Occupational Therapist, the Ward Clerk, two Registered Nurses, one previously employed Registered Nurse, three Registered Practical Nurses, three Personal Support Workers (PSW), one Dietary Aide, one Fanshawe College PSW Student, five residents, and two family members.

The inspector(s) also made observations of residents, activities and care. Relevant policies, procedures and program evaluations, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service and resident/staff interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **7 VPC(s)**
- **4 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 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 residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) Record review of the progress notes documented an area of altered skin integrity for a resident.

Interview with the Resident Assessment Instrument Coordinator (RAI-C) shared that all skin and wound assessments were completed in the Pixalere electronic documentation system and no other means of documentation in the resident's clinical record demonstrated that an assessment was completed. Pixalere was specifically designed for skin and wound assessments and acts as a clinically appropriate assessment instrument capturing all appropriate skin and wound documentation, monitoring, assessment and treatment. The RAI-C shared there was nothing documented in Pixalere related to the altered skin integrity. The RAI-C shared that the resident should have received a skin assessment by a member of the registered nursing staff using the Pixalere documentation system.

B) Record review of the progress notes documented an area of altered skin integrity for a

resident.

Interview with the RAI-C shared that there was no assessment completed related to the altered skin integrity for this resident. The RAI-C shared that the resident should have received a skin assessment by a member of the registered nursing staff who treated the skin tear by using the Pixalere documentation system.

C) Record review of the progress notes documented an area of altered skin integrity for a resident.

The resident was observed with an area of altered skin integrity.

Interview with the RAI-C shared there was nothing documented in Pixalere related to the area of altered skin integrity. The RAI-C shared that the resident should have received a skin assessment by a member of the registered nursing staff using the Pixalere documentation system.

The licensee failed to ensure that when the residents had an area of altered skin integrity, a skin assessment was completed by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

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

Record review of the progress notes documented an area of altered skin integrity for a resident.

Interview with the RAI-C shared that all skin and wound assessments were completed in the Pixalere electronic documentation system. The RAI-C shared that the initial wound assessment for a resident was completed in Pixalere. The closed assessment was also completed with nothing else documented weekly. The RAI-C shared that it was clinically indicated that the altered skin integrity was to be reassessed weekly and it was the home’s expectation that skin and wound assessments be completed weekly until the altered skin integrity was healed.

The licensee failed to ensure that the resident's altered skin integrity had been

reassessed at least weekly by a member of the registered nursing staff.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. There was a compliance history of this legislation being issued in the home on December 8, 2014 as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2014_229213_0078. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

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

A) Family member indicated that they observed a resident seated and slouched. The family member also shared that fluid and food was observed down the front of the resident's clothing and that the Director of Nursing (DON) was standing with nursing staff with her back to the resident and when the family member addressed the appearance of the resident, the DON stated that the resident required to be "cleaned up".

A photograph of the resident showed the resident in a chair slouched to the right side and leaning forward. There were no interventions in place to support the resident's posture and to provide comfort. There also appeared to be a large dark spot on the resident's anterior upper clothing. Another photograph showed the resident sitting upright wearing clean dry clothing with an intervention in place to provide support and comfort one hour later. Another photograph taken, approximately three hours later, showed the resident was soaked with fluid on the resident's clothing and the resident was slouched and leaning to the right.

The DON verified that she had directed staff to stay past shift to "clean the resident up".

B) The resident remained in the dining room seated at a table that contained dirty dishes, cutlery and leftover food and fluids. The resident was observed scraping food debris and was observed as ungroomed, dirty and with uncut fingernails. The dining room was observed with no staff present with the exception of a housekeeper until a Personal Support Worker (PSW) arrived.

Record review of the Minimum Data Set (MDS) Quarterly review assessment under the self performance section for activities of daily living indicated that the resident required staff assistance for dressing and personal care.

C) The resident was observed with drool on hands and face. A large area was soiled on the resident's clothing and the resident's pants were saturated. The sheet that was on the resident's knees and floor was dirty and soaked. Observed numerous staff walk by and did not stop to address the resident's appearance. The resident was observed again on a different day with clothing saturated with brown and orange liquid matter. On another day, the resident was observed with fluid that dripped down the face and onto the resident's clothing that was saturated. Numerous staff walked by when an unknown staff member stopped, and after an extended period of time, told the inspector that she "would change the clothes".

Record review of the Minimum Data Set (MDS) Quarterly review assessment under the self performance section for activities of daily living indicated that the resident required staff assistance for dressing and personal care.

D) The resident was observed with shoes layered in spatter and fluid on the face and neck. Numerous staff walked by. On a different day, the resident was seated at a table and was observed with drool and thick mucous on the face until staff were asked to clean the resident up. Again the resident was observed lying with orange crusted lips and uncut and dirty fingernails. On another day, the resident was observed with thick orange drool on face and onto the resident's clothing that was soiled and saturated. Numerous staff walked by when an unknown staff member stopped and told the inspector that she "would clean the resident up".

Record review of the Minimum Data Set (MDS) Quarterly review assessment under the self performance section for activities of daily living indicated that the resident required

staff assistance for dressing and personal care.

E) Interview with the RAI-C indicated that the family member of the resident came to the office door with the resident who had a dirty face. The RAI-C explained that she took both the family member and the resident to the office of the Director of Nursing (DON) to immediately report the family's concern and the current condition of the resident. The RAI-C agreed that the resident was not properly groomed and should be.

A family member submitted a complaint to the Ministry of Health and Long-Term Care (MOHLTC) that reported concerns that the resident was not cleaned and had food stained pants and food debris on the legs, clothes and wheelchair.

Registered Practical Nurse (RPN), RAI Coordinator, RN and RPN Behavioural Supports Ontario (BSO) indicated that a resident should not have a dirty face, hands, nails or clothes as this was disrespectful and neglectful. The Director of Nursing (DON) verified that a resident left for a long period of time, a resident that was soiled or not properly bathed or positioned, was not cared for.

Record review of the Caresssant Care Nursing & Retirement Home Ltd., Schedule "A" titled Residents Bill of Rights dated July 2010 verified that every resident had the right to be properly fed, clothed, groomed and cared for.

Record review of the most recent Caressant Care Nursing and Retirement Homes-Dietary Audit tool titled Meal Delivery/Dining Room Audit indicated that "resident's hands and face were not cleaned before leaving the dining room". The acting Administrator indicated that the audit was the only evaluation tool used by the Dietary Program and was completed "possibly in the year 2015". The acting Administrator also verified that the Dietary Program Audit was not completed for the year 2016 at all.

The licensee has failed to ensure that specified residents received individualized personal care, including hygiene care and grooming, on a daily basis.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection for five of five residents with a history of unrelated non-compliance. [s. 32.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of neglect of a resident that the licensee knows of, or that was reported to the licensee was investigated immediately and appropriate action was taken in response to every such incident and the licensee failed to report to the Director the results of every investigation.

"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.

A resident's family member indicated that they observed the resident was found sitting slouched in a chair with fluids and food on their clothing. The family shared that the DON was standing with nursing staff with her back to the resident when the family told the DON that there were concerns about the resident's appearance. Later that day, the family member again observed the resident's clothing was wet with fluids.

A photograph of the resident showed the resident in a chair slouched to the right side and leaning forward. There were no interventions in place to support the resident's posture and to provide comfort. There also appeared to be a large dark spot on the resident's anterior upper clothing. Another photograph showed the resident sitting upright wearing clean dry clothing with an intervention in place to provide support and comfort one hour later. Another photograph taken, approximately three hours later, showed the resident was soaked with fluid on the resident's clothing and the resident was slouched and leaning to the right.

The Director of Nursing (DON) shared that they overheard a family member tell another person about the allegations of neglect related tot he resident's care. The DON

acknowledged that she heard the allegation of neglect. The DON also shared that the home did not investigate "too much" and staff were not interviewed. There was no documentation to support an investigation occurred and the DON acknowledged that she did not feel this was an incident of neglect and therefore did not investigate.

Interview with Registered Practical Nurse Behavioural Supports Ontario (RPN BSO) indicated that the resident was often "flopped in the chair" and that an OT assessment should have been completed and was not. (633)

The DON shared that the resident usually had an intervention in place to support the resident's posture and to provide comfort. The DON could not recall seeing the intervention in place at the time of the incident.

The acting Administrator shared that it was the home's responsibility to investigate any suspected or alleged neglect.

The licensee failed to immediately investigate an allegation of neglect of a resident and the home did not take appropriate action in response to this incident. [s. 23.]

2. The Director of Nursing (DON) submitted a Critical Incident System Report to the Ministry of Health and Long-Term Care (MOHLTC) to inform the Director of the alleged neglect of the resident. The family member of a resident submitted a complaint to the MOHLTC that also reported the alleged neglect of the resident.

The resident was to be provided specific interventions during meals. The progress notes in PointClickCare (PCC) verified that the resident sustained an injury during a meal. Observation of the resident's injury verified that the injury was healing, but still remained.

Record review of the Policy and Procedure titled Response to Complaints last reviewed on February 2014 indicated that "all complaints will be documented, investigated and formally responded to promptly utilizing the Report of Complaint form". Record review of the Policy and Procedure titled Abuse & Neglect-Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to staff last reviewed August, 2016 indicated that Mandatory Reporting included the DON "immediately notifying the Administrator of the initiation of an investigation" and that the DON and/or Administrator will interview all parties and maintain a written record using the Abuse-Resident Incident Report".

The Dietary Aide that served the meal to the resident and the Food and Nutrition Manager indicated that neither staff had been interviewed by management related to the resident's injury and the Food and Nutrition Manager was not aware that the incident had occurred at all.

The DON and record review of the Complaint Form that was completed by the DON verified that there was no documentation related to the resident's injury. No other additional documentation was completed and an evaluation was not done as there were no investigative steps taken including no interviews with relevant staff, and no review of one of the home's identified policies last reviewed July 2016. There was no report to the Director (MOHLTC) of the results of the investigation by an amendment to the critical incident report made to the MOHLTC or otherwise.

Interview with acting Administrator verified that the expectation would be that an investigation should have been done and a report to the Director (MOHLTC) of the results of the investigation should have been made by the DON and submitted to the Director and was not.

The licensee has failed to ensure that the alleged, suspected or witnessed incident of neglect of a resident that was reported to the licensee was investigated and the results of the investigation reported to the Director (MOHLTC).

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. There was a compliance history of this legislation being issued in the home on August 30, 2016 as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2016_326569_0021. [s. 23.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Findings/Faits saillants :

1. 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

Record review of the current care plan for specified residents documented interventions related to the eating support required at snacks and meals.

A Personal Support Worker (PSW) shared the intervention for eating assistance was vague and broad. The PSW also stated that a more descriptive and specific intervention would be helpful and agreed that the intervention was not individualized to a resident. A PSW Student also shared that the intervention was not clear, and that it provided a guideline for care that was not specific.

The Resident Assessment Instrument Coordinator (RAI-C) shared that the level of assistance for the activity of eating was unclear to staff and others who provided direct care to the resident. The RAI-C also shared that the specific level of assistance was unclear since "extensive," "limited" or "supervision" did not describe what was to be supervised or what part of the meal required limited or extensive assistance.

The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care related to eating assistance to the residents. LTCHA, 2007, S.O. 2007, c.8, s. 6 (1) c

The severity was determined to be a level 1 as there was minimal harm. The scope of this issue was isolated with a compliance history of s. 6 (1) being issued in the home on August 30, 2016 as a Written Notification (WN) in a Resident Quality Inspection #2016_326569_0021 and a compliance history of s. 6 (1)(b) being issued in the home on December 8, 2014 as a Written Notification (WN) in a Resident Quality Inspection #2014_229213_0078. [s. 6.]

2. s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

The licensee failed to ensure staff and others who provided direct care to a resident, were kept aware of the contents of the plan of care and had convenient and immediate access to it.

A) Record review of the current care plan and kardex documented specific interventions for a resident to address specific behaviours.

The resident was observed by inspectors and specific interventions documented were not followed.

The Registered Practical Nurse shared interventions for care provided by Personal Support Workers (PSWs) were on the kardex or task list and PSWs only access the kardex for care plan interventions.

The RPN Behavioural Supports Ontario (BSO) acknowledged that specific interventions in the current plan of care were not accessible to PSWs and verified that only those interventions that have been dedicated to the kardex were viewed by the PSW staff in Point of Care (POC).

B) Record review of the current care plan and kardex for the resident documented specific interventions related to protective garments, skin care and behaviours.

On specified days the resident was observed before a meal or snack without the use of a protective garment and clothing was soaked with fluid.

The RPN BSO acknowledged the interventions related to the resident were not added to the kardex for PSWs.

The Personal Support Worker (PSW) and the PSW Student clicked the kardex button in Point of Care (POC) and shared that the "Kardex Summary" on POC provided the summary of resident care for PSWs to follow and verified that PSWs did not have access to the care directions in the plan of care.

The licensee failed to ensure staff and others who provided direct care to the residents

were kept aware of the contents of the plan of care and had convenient and immediate access to it. LTCHA, 2007, S.O. 2007, c.8, s. 6 (8)

The severity was determined to be a level 3 as there was actual harm/risk. The scope of this issue was widespread during the course of this inspection with a history of unrelated non-compliance.

3. 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).

The licensee has failed to ensure that every resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed and the care set out in the plan was no longer effective.

A) A Critical Incident System Report and Complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) to inform the Director of the alleged neglect of the resident.

Record review of the current care plan indicated that a resident required assistive eating devices at meals.

Record review of the progress notes in PointClickCare (PCC) indicated that the resident was injured during a meal.

The PSW, Nurse's Aide, PSW Student, RPN, RPN BSO, Director of Nursing (DON) verified that registered staff refer to the care plan and PSWs rely on the kardex in PCC to obtain resident care information.

Record review of the care plan and kardex in PCC for a resident verified that specific interventions related to eating assistance were not added to the care plan until several days after the incident.

The RPN, RAI-C, RPN BSO and Director of Nursing (DON) verified the care plan for a resident should have been updated immediately, or sooner than a week or more, and

was not.

The licensee has failed to ensure that the plan of care was revised the current plan was no longer effective.

B) Record review of the plan of care in PointClickCare (PCC) indicated that a resident used a specific device for mobility provided by the home and a record review of the progress notes in PCC for the resident indicated several near miss falls, injuries, poor posture and a change in mobility.

Record review of the current care plan in PCC for the resident noted that interventions related to positioning and safety were not documented.

Record review of the Minimum Data Set (MDS) admission, quarterly and annual assessments in PCC demonstrated that the resident had a change in mobility.

The Occupational Therapy (OT) referral form indicated that a resident required an assessment.

Interview with the OT indicated that the resident had not received OT services for several months and was not prioritized and assessed for positioning and safety.

Registered Practical Nurse Behavioural Supports Ontario (RPN BSO) indicated that a resident had physically and cognitively declined since admission and that an OT assessment should have been completed and was not.

Interview with the RAI-C indicated that care plan reviews were completed quarterly based on the MDS Bedside Assessment Tool completed by the registered staff and that activities of daily living (ADLs) and safety items have the highest priority when checking the care plan for accuracy.

The Personal Support Worker (PSW), Nurse's Aide, PSW Student, RPN, RPN BSO, and Director of Nursing (DON) verified that registered staff referred to the care plan and PSWs rely on the kardex in PCC to obtain resident care information.

C) The licensee failed to ensure a resident was reassessed and the plan of care was reviewed and revised when a resident's care needs changed.

Record review of the current care plan and kardex on for the resident documented there were no interventions related to the use of specific intervention used for posture and support.

Record review of the Minimum Data Set (MDS) assessment documented that the resident had functional limitation in range of motion with partial loss of voluntary movement.

A resident's family member shared they have shown staff how to apply the specific intervention to position a resident safely to reduce the risk of sliding and falling and staff have not complied.

The Registered Practical Nurse (RPN) shared that a resident was often uncomfortable and was given interventions for support.

The Director of Nursing (DON) shared the resident was physically supported with a specific intervention and shared that staff would know to use the intervention by referring to the care plan or kardex.

The RPN Behavioural Supports Ontario (BSO) acknowledged that there were no interventions in the care plan or kardex related to the use of the specific intervention for positioning and maintenance of posture.

The licensee has failed to ensure that the plan of care was revised when a resident's functional limitation changed.

D) Record review of the current care plan and kardex for a resident stated specific interventions related to behaviours.

Observations of a resident on three separate dates demonstrated the resident did not exhibit these behaviours.

The RPN BSO shared that a resident no longer exhibited specific behaviours. The RPN BSO acknowledged that the interventions were no longer necessary.

The licensee has failed to ensure that the plan of care was revised when care needs changed. LTCHA, 2007, S.O. 2007, c.8, s. 6 (10)

The severity was determined to be a level 3 as there was actual harm/risk. The scope of this issue was widespread during the course of this inspection with a history of unrelated non-compliance. [s. 6.]

Additional Required Actions:

CO # - 004 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 the plan of care set out clear directions to staff and others who provided direct care to the resident, to be implemented voluntarily.

WN #5: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Record review of the Caresssant Care Nursing & Retirement Home Ltd. Policy and Procedure titled "Reporting Near Misses" stated when a near miss has been identified, it will be documented on a Near Miss Report Form including a description of the circumstance and how an incident was eluded. The policy stated that near misses would be present at the Continuous Quality Improvement Team meeting by the supervisor, near misses would be discussed at all staff meetings and the Administrator would maintain a

record of all near misses including numbers of incidents as part of the monthly indicator tracking. This policy as it related to the near miss falls for the resident was required by s. 30(1) as part of the written description of the falls prevention program.

The progress note documented that the resident was restless in bed and was found half out of bed. There was no documented evidence of a Near Miss Reporting Form completed related to this incident. There was also no record of an incident documented as part of Risk Management in PointClickCare (PCC).

Record review of the progress notes documented numerous near miss falls and there was no documented evidence of a Near Miss Reporting Form completed and no record of an incident documented as part of Risk Management in PCC.

The RPN shared that near miss documentation would be completed as a progress note and shared that when staff need to assist to lower a resident to the floor or if a resident was half out and half in bed, it would be considered a near miss fall.

The acting Administrator shared that the process for near miss incidents should be documented as part of the Risk Management in PCC. The acting Administrator shared that there were no near miss forms completed, shared at staff meetings, maintained by the Administrator and there was no tracking system in place that included a record of the number of near misses monthly.

The severity was determined to be a level 1 as there was minimal harm. The scope of this issue was isolated with a compliance history of this legislation being issued in the home on:
- August 30, 2016 as a Written Notification (WN) in a Resident Quality Inspection #2016_326569_0021
- October 19, 2015 as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2015_416515_0030
- October 16, 2014 as a Written Notification (WN) in a Critical Incident Inspection #2014_303563_0044
- May 14, 2014 as a Voluntary Plan of Correctio n (VPC) in a Critical Incident Inspection #2014_260521_0024 [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 ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, a resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Record review of the current care plan for a resident stated bed rails were in use.

Record review of the progress notes and the Minimum Data Set (MDS) Outcome Scores documented a change in cognitive and physical functioning.

The Registered Practical Nurse (RPN) shared that a resident demonstrated a change in physical and cognitive function.

The RPN stated a Side-Rail Use Assessment Form should be completed with any change to a resident or the bed. The RPN shared that the resident was documented as having bed rails in use and shared that the expectation was to complete the Side-Rail Use Assessment Form when any resident started using side rails or when a resident's physical and/or cognitive status changed.

The acting Administrator shared that with the cognitive and physical changes of a resident, the use of bed rails and in light of the near miss incidents, a Side Rail Use Assessment Form should have been completed. The acting Administrator also shared that the entrapment policy stated a change in physical/cognitive status of a resident, a resident risk assessment would be completed.

The licensee has failed to ensure that when the use of bed rails for a resident was initiated, a resident had been assessed and the bed system evaluated to minimize risk to the resident.

The severity was determined to be a level 1 as there was minimal harm. The scope of this issue was isolated with a compliance history of r. 15 (1)(a) being issued in the home on December 8, 2014 as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2014_229213_0078. [s. 15. (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 where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

Record review of the Caresssant Care Nursing & Retirement Home Ltd. Policy and Procedure, Schedule D titled Abuse & Neglect- Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff reviewed August 2016 stated all cases of suspected or actual abuse must be reported in written form to the Director of Nursing (DON)/Administrator and in the absence of management, to notify the charge nurse immediately who will contact manager on call.

Record review of the progress note for the resident described an allegation of physical abuse by a staff member.

The RN shared that the allegation of suspected physical abuse by a staff member towards the resident was not investigated or reported to management. The RN shared that she did not feel it was abuse because a resident "often said things that were unrealistic." The RN acknowledged there was no follow up or assessment of a resident after the allegation of physical abuse was documented in the progress notes.

The acting Administrator shared that all staff were to report all cases of suspected or actual abuse to management and this incident was not reported.

The licensee has failed to ensure that when a resident reported physical abuse by a staff member, the RN reported the allegation to the Director of Nursing (DON)/Administrator.

The severity was determined to be a level 2 as there was minimal risk. The scope of this issue was isolated with a compliance history of this legislation being issued in the home on July 13, 2016 as a Written Notification (WN) in a Critical Incident Inspection #2016_303563_0021. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in

accordance with prevailing practices.

Record review of the “Skin and Wound Care Management Program Evaluation" documented a review date of January 10, 2017. The program was not evaluated and updated in 2016 as part of the home's skin and wound care program.

The acting Administrator shared that the Skin and Wound Care Management Program was not evaluated and updated at least annually in 2016.

The licensee failed to ensure that the required program identified above was evaluated and updated at least annually. [s. 30. (1) 3.]

2. The licensee has failed to ensure that the Personal Support Services Program was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The acting Administrator indicated that the home did not have a program that was specific to personal support services that was related to assistance with activities of daily living, personal hygiene services and supervision in those activities. The acting Administrator indicated that resident care audits related to personal support services were completed monthly and reviewed by the Resident Care Coordinator (RCC) and explained that the expectations of the Personal Support Worker (PSW) was found in the job description.

The Director of Nursing (DON) indicated the DON was not aware of an annual written evaluation of the personal support services. The DON stated that a walk through was done once a week or so by the managers, Resident Care Coordinator (RCC) and the Assistant Director of Nursing (ADON). The DON could not comment on who evaluated the personal support services monthly and for patterns overtime as the ADON was no longer working at the home.

Record review of the monthly Resident Care Audit completed by ADON indicated that of 12 residents observed three residents did not have clothes that were clean and in a good state of repair, one resident did not have a clean face or eyes, five residents did not have neatly combed hair and did not appear groomed and one resident did not have trimmed nails.

Record review of the monthly resident care audits for the year 2016 indicated that

resident care audits were completed for one month only.

Record review of the Caressant Care Nursing and Retirement Home Ltd. titled Job description-Personal Support Worker/Nurse Aide indicated that the last reviewed date was September 2015.

Record review of the Continuous Quality Improvement (CQI) meeting minutes dated January 29, March 10, May 30, August 9, 2016 in the item section "Nursing" was blank and personal support services was not included.

Record review of the Quality Improvement Quarterly report dated December 2015 and draft Quality Improvement Quarterly report dated 2016 indicated that personal support services and resident care audits were not included.

The licensee has failed to ensure that the Personal Support Services evaluated annually in accordance with evidence-based practices and, if there were none, that was in accordance with prevailing practices. (633)

The severity was determined to be a level 1 as there was minimal harm. The scope of this issue was isolated with a similar compliance history of s.30.(1) 1 being issued in the home on May 14, 2014 as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2014_260521_0024. [s. 30. (1) 3.]

3. The licensee has failed to ensure that a written record relating to each evaluation included a summary of the changes made and the date that those changes were implemented.

Record review of the "Fall Prevention/Resident Safety Plan Program Evaluation" dated May 19, 2016 documented a summary of the changes made over the past year with no date when the changes were implemented as part of the falls prevention and management program.

Record review of the "Therapy Services Program Evaluation" dated September 8, 2016 documented a summary of the changes made over the past year with no date when the changes were implemented as part of the restorative care program. The Therapy Services Program included physiotherapy, occupational therapy and speech-language therapy services offered as required in the home.

Record review of the "Continence Care & Bowel Management Program Evaluation" dated September 8, 2016 documented a summary of the changes made over the past year with no date when the changes were implemented as part of the continence care and bowel management program.

Record review of the "Skin and Wound Care Management Program Evaluation" dated January 10, 2017 documented a summary of the changes made over the past year with no date when the changes were implemented as part of the skin and wound care program.

The acting Administrator #101 shared that the "Fall Prevention/Resident Safety Plan Program Evaluation" did not include the date that those changes were implemented and acknowledged that multiple program evaluations did not include that date the changes were implemented.

The licensee failed to ensure that a written record relating to evaluation of the identified required programs listed in s. 8-16 of the Act and s. 48 of the Regulation included a summary of the changes made and the date that those changes were implemented. [s. 30. (1) 4.]

4. The licensee has failed to ensure a written record relating to each evaluation included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A family member indicated that the resident family member had visited the home and found the resident seated and slouched. It was additionally shared that fluid and food was observed on the resident's clothing.

A resident was observed by inspectors in the dining room, approximately two hours after lunch, seated at a table that contained stacked dirty dishes, cutlery and leftover food and fluids. A PSW, then the Ward Clerk and Registered Practical Nurse Behavioural Support Ontario (RPN BSO) arrived at the dining room and cleared after lunch.

During the course of the inspection specified residents were not treated with respect and dignity as they were observed as not properly clothed, groomed and cared for in a manner consistent with their needs.

Another family member submitted a complaint to the Ministry of Health and Long-Term

Care (MOHLTC) that reported concerns that the resident was injured during a meal.

Interview with the acting Administrator indicated that the home did not have a program that was specific to the personal support services in the home. The acting Administrator explained that personal support services were evaluated within the Nursing Restorative Care Program and other programs, resident care audits were completed monthly that were reviewed by the Resident Care Coordinator (RCC) and the expectations of the Personal Support Worker (PSW) was found in the job description.

Record review of the letter received by fax by acting Administrator documented "PSW program- There is no formal program. The responsibilities, goals and evaluation of the PSW is embedded in the individual policies but also outlined in the job description of the Personal Support Worker (attached). The Quarterly Risk Management Report includes reviewing Resident Care. The monthly resident care audit (attached) is used to assist with this review".

The Director of Nursing (DON) indicated that the DON was unaware of a written description of the personal support services that included goals and objectives and methods to reduce risk and monitor resident outcomes. The DON was also "unsure" of an annual written evaluation related to the personal supports services in the home and stated that a "walk through was done once a week or so by the managers, the RCC and the Assistant Director of Nursing (ADON)" and that the ADON no longer worked in the home.

Record review of the policy titled Caressant Care Nursing and Retirement Homes Ltd-Audits-Departmental with last reviewed date of August, 2014 indicated that each department will audit the service provided, action plans will be developed and the results will be analyzed through the Quality Improvement Committee Record review of the policy titled Caressant Care Nursing and Retirement Homes Ltd Audits-and that records would be maintained for two years. The department nursing indicator Resident Care indicated ten percent of each resident unit would be audited per month.

Record review of the policy titled Caressant Care Nursing and Retirement Homes Ltd-Annual Continuous Quality Improvement (CQI) Goals and Objectives with last review date of March, 2015 indicated that each department will set annual goals that were measurable, action plans would be developed and presented to the Quality Improvement Team that reviewed the goals at least quarterly, analyzed outcomes, revised action plans that would be communicated to residents, family and staff.

Record review of the policy titled Caressant Care Nursing and Retirement Homes Ltd-Daily Walk – Through Monitoring" had an effective date of May 2011 with no documented review date, indicated the Administrator and DON walk through the home at the beginning of their shift, areas of concern were identified, discussed between managers, corrective action would be planned and the results would be brought to CQI monthly for evaluation.

Record review of the policy titled Caressant Care Nursing and Retirement Homes Ltd-Program Evaluation had an effective date of April 2014 with a documented review date of April 2014. The policy indicated that programs were to be evaluated and updated annually and the information was brought to the CQI meeting and reviewed to identify improvement opportunities.

Record review of the Restorative Care Program Evaluation dated March 16, 2016 completed by Registered Nurse (RN) and previous ADON indicated a goal of "to maintain or increase the function of activities of daily living (ADLs) for the resident, ADLs and communication" and the date the results were taken to the Quality Improvement Committee was blank.

Record review of the monthly resident care audits for the year 2016 indicated that resident care audits were completed on September 29, 2016 only and no concerns related to resident care were identified. During a telephone interview, the Registered Nurse/Resident Care Coordinator (RN/RCC), shared that they were newly employed in the home at that time and completed the audits. RN/RCC indicated that resident care was not observed and that only room and chart audits were completed.

Record review of the Resident Care Audits that were completed by the previous Assistant Director of Nursing (ADON) indicated that of 12 residents were observed and three residents did not have clothes that were clean and in a good state of repair, one resident did not have a clean face or eyes, five residents did not have neatly combed hair and did not appear groomed and one resident did not have trimmed nails.

Record review of the 2016 Quality Improvement/Risk Quarterly Report that was faxed by the acting Administrator was blank with the exception that the Resident Care box had a hand written star and the word "audits".

Record review of the Quality Improvement Quarterly report dated December 2015 and

draft Quality Improvement Quarterly report dated 2016 indicated that personal support services were not documented in any program evaluation, the Resident Care Audits dated November 4 and 5, 2015 and the Restorative Care Program results and implemented changes were not included.

Record review of the CQI meeting minutes dated January 29, March 10, May 30, August 9, and September 8, 2016 indicated personal support services were not included.

Record review of the Caressant Care Nursing and Retirement Home Ltd. titled "Job description-Personal Support Worker/Nurse Aide" indicated that the last reviewed date was September, 2015.

The licensee has failed to keep a written record relating to the nursing and personal support services evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The severity was determined to be a level 1 as there was minimal harm. The scope of this issue was isolated with a similar compliance history of s.30.(1) 1 being issued in the home on May 14, 2014 as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2014_260521_0024. [s. 30. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and to ensure a written record relating to each evaluation included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the behavioural triggers were identified and strategies were implemented to respond to the needs of each resident that demonstrated responsive behaviours.

Record review of the plan of care in PointClickCare (PCC) indicated that a resident experienced symptoms of decline.

Record review of the care plan indicated that the resident had behavioral symptoms.

The current care plan did not include behavioral triggers, strategies and interventions.

Personal Support Worker (PSW), Nurse’s Aide, PSW Student, Registered Practical Nurse (RPN), RPN BSO, and Director of Nursing (DON) verified that registered staff referred to the care plan and PSWs rely on the kardex in PCC to obtain resident care information.

The RPN BSO acknowledged that the interventions and strategies related to the resident's responsive behaviours were not identified and implemented into the care plan or kardex.

The licensee has failed to ensure that the behavioural triggers were identified and strategies were implemented to respond to the needs of the resident that demonstrated responsive behaviours.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated with with a history of unrelated non-compliance. [s. 53. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the behavioural triggers are identified and strategies are implemented to respond to the needs of each resident that demonstrate responsive behaviours, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident were promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified.

A family member indicated that the home did not contact them related to falls, injuries and changes to the resident's condition. The family member shared that they received a phone call that the resident had a fall, but staff did not notify them of the extent of the resident's injuries.

The photograph of the resident was reviewed and showed the resident had a significant injury.

Record review of the progress notes demonstrated there was no documented evidence that the Power of Attorney (POA) was made aware of the injury until several days later.

The Director of Nursing (DON) shared a member of the registered staff would contact a family member / POA when a resident had sustained a fall, if there was a significant change in the resident's condition, or if there was a medication change. The family member would be called and given an opportunity to participate fully in the development and implementation of the resident's plan of care.

B) Record review of a family conference stated a family concern where a family member was not contacted about an acute medical condition and treatment plan.

Record review of the Lab/Diagnostic Notes documented the onset of an acute medical condition.

Record review of the electronic Medication Administration Report (eMAR) in PointClickCare (PCC) documented that a treatment plan had commenced.

Record review of the progress notes demonstrated that a family member of the resident was not contacted when this new treatment was started and given an opportunity to participate fully in the development and implementation of the resident's plan of care. LTCHA, 2007, S.O. 2007, c.8, s. 6 (5)

The severity was determined to be a level 2 as there was minimal harm/risk or potential for actual harm/risk. The scope of this issue was isolated during the course of this inspection with a history of unrelated non-compliance. [s. 107. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified, to be implemented voluntarily.

Issued on this 28th day of January, 2017

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 soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELANIE NORTHEY (563), SHERRI COOK (633)
Inspection No. / No de l'inspection :	2016_303563_0042
Log No. / Registre no:	033550-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 24, 25, 2017
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 WOODSTOCK NURSING HOME 81 FYFE AVENUE, WOODSTOCK, ON, N4S-8Y2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gay Goetz

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 :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(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).

Order / Ordre :

The licensee shall ensure that specified residents and all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Specifically, the home will ensure that there is a process to:
• Educate all nursing staff related to the types of altered skin integrity, roles and responsibilities related to recognition, reporting, documentation, assessments and appropriate strategies
• Educate all registered staff related to the process for completing a skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and the process for completing a skin assessment when the home's software for skin assessments is inaccessible;
• Develop and implement a tracking and monitoring system for all altered skin integrity in the home, including assessments and reassessments;
• Develop and implement a process for tracking staff education to ensure completion.
• Ensure that a written record related to the annual evaluation of the skin and wound care management program including the summary of changes made and the date those changes were implemented is completed.

Grounds / Motifs :

1. The licensee failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) Record review of the progress notes documented an area of altered skin integrity for a resident.

Interview with the Resident Assessment Instrument Coordinator (RAI-C) shared that all skin and wound assessments were completed in the Pixalere electronic documentation system and no other means of documentation in the resident's clinical record demonstrated that an assessment was completed. Pixalere was specifically designed for skin and wound assessments and acts as a clinically

appropriate assessment instrument capturing all appropriate skin and wound documentation, monitoring, assessment and treatment. The RAI-C shared there was nothing documented in Pixalere related to the altered skin integrity. The RAI-C shared that the resident should have received a skin assessment by a member of the registered nursing staff using the Pixalere documentation system.

B) Record review of the progress notes documented an area of altered skin integrity for a resident.

Interview with the RAI-C shared that there was no assessment completed related to the altered skin integrity for this resident. The RAI-C shared that the resident should have received a skin assessment by a member of the registered nursing staff who treated the skin tear by using the Pixalere documentation system.

C) Record review of the progress notes documented an area of altered skin integrity for a resident.

The resident was observed with an area of altered skin integrity.

Interview with the RAI-C shared there was nothing documented in Pixalere related to the area of altered skin integrity. The RAI-C shared that the resident should have received a skin assessment by a member of the registered nursing staff using the Pixalere documentation system.

The licensee failed to ensure that when the residents had an area of altered skin integrity, a skin assessment was completed by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)] (563)

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

Record review of the progress notes documented an area of altered skin integrity for a resident.

Interview with the RAI-C shared that all skin and wound assessments were completed in the Pixalere electronic documentation system. The RAI-C shared that the initial wound assessment for a resident was completed in Pixalere. The closed assessment was also completed with nothing else documented weekly. The RAI-C shared that it was clinically indicated that the altered skin integrity was to be reassessed weekly and it was the home's expectation that skin and wound assessments be completed weekly until the altered skin integrity was healed.

The licensee failed to ensure that the resident's altered skin integrity had been reassessed at least weekly by a member of the registered nursing staff.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. There was a compliance history of this legislation being issued in the home on December 8, 2014 as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2014_229213_0078. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 01, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Order / Ordre :

The licensee shall ensure that specified resident and all residents of the home receive individualized personal care, including hygiene care and grooming, on a daily basis.

The licensee shall ensure that there is a mechanism in place to identify which staff are responsible for resident assignments including the staff responsible for ensuring and monitoring the daily resident care needs.

Grounds / Motifs :

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

A) Family member indicated that they observed a resident seated and slouched. The family member also shared that fluid and food was observed down the front of the resident's clothing and that the Director of Nursing (DON) was standing with nursing staff with her back to the resident and when the family member addressed the appearance of the resident, the DON stated that the resident required to be "cleaned up".

A photograph of the resident showed the resident in a chair slouched to the right side and leaning forward. There were no interventions in place to support the resident's posture and to provide comfort. There also appeared to be a large dark spot on the resident's anterior upper clothing. Another photograph showed the resident sitting upright wearing clean dry clothing with an intervention in place to provide support and comfort one hour later. Another photograph taken, approximately three hours later, showed the resident was soaked with fluid on

the resident's clothing and the resident was slouched and leaning to the right.

The DON verified that she had directed staff to stay past shift to "clean the resident up".

B) The resident remained in the dining room seated at a table that contained dirty dishes, cutlery and leftover food and fluids. The resident was observed scraping food debris and was observed as ungroomed, dirty and with uncut fingernails. The dining room was observed with no staff present with the exception of a housekeeper until a Personal Support Worker (PSW) arrived.

Record review of the Minimum Data Set (MDS) Quarterly review assessment under the self performance section for activities of daily living indicated that the resident required staff assistance for dressing and personal care.

C) The resident was observed with drool on hands and face. A large area was soiled on the resident's clothing and the resident's pants were saturated. The sheet that was on the resident's knees and floor was dirty and soaked. Observed numerous staff walk by and did not stop to address the resident's appearance. The resident was observed again on a different day with clothing saturated with brown and orange liquid matter. On another day, the resident was observed with fluid that dripped down the face and onto the resident's clothing that was saturated. Numerous staff walked by when an unknown staff member stopped, and after an extended period of time, told the inspector that she "would change the clothes".

Record review of the Minimum Data Set (MDS) Quarterly review assessment under the self performance section for activities of daily living indicated that the resident required staff assistance for dressing and personal care.

D) The resident was observed with shoes layered in spatter and fluid on the face and neck. Numerous staff walked by. On a different day, the resident was seated at a table and was observed with drool and thick mucous on the face until staff were asked to clean the resident up. Again the resident was observed lying with orange crusted lips and uncut and dirty fingernails. On another day, the resident was observed with thick orange drool on face and onto the resident's clothing that was soiled and saturated. Numerous staff walked by when an unknown staff member stopped and told the inspector that she "would clean the resident up".

Record review of the Minimum Data Set (MDS) Quarterly review assessment under the self performance section for activities of daily living indicated that the resident required staff assistance for dressing and personal care.

E) Interview with the RAI-C indicated that the family member of the resident came to the office door with the resident who had a dirty face. The RAI-C explained that she took both the family member and the resident to the office of the Director of Nursing (DON) to immediately report the family's concern and the current condition of the resident. The RAI-C agreed that the resident was not properly groomed and should be.

A family member submitted a complaint to the Ministry of Health and Long-Term Care (MOHLTC) that reported concerns that the resident was not cleaned and had food stained pants and food debris on the legs, clothes and wheelchair.

Registered Practical Nurse (RPN), RAI Coordinator, RN and RPN Behavioural Supports Ontario (BSO) indicated that a resident should not have a dirty face, hands, nails or clothes as this was disrespectful and neglectful. The Director of Nursing (DON) verified that a resident left for a long period of time, a resident that was soiled or not properly bathed or positioned, was not cared for.

Record review of the Caresssant Care Nursing & Retirement Home Ltd., Schedule "A" titled Residents Bill of Rights dated July 2010 verified that every resident had the right to be properly fed, clothed, groomed and cared for.

Record review of the most recent Caressant Care Nursing and Retirement Homes-Dietary Audit tool titled Meal Delivery/Dining Room Audit indicated that "resident's hands and face were not cleaned before leaving the dining room". The acting Administrator indicated that the audit was the only evaluation tool used by the Dietary Program and was completed "possibly in the year 2015". The acting Administrator also verified that the Dietary Program Audit was not completed for the year 2016 at all.

The licensee has failed to ensure that specified residents received individualized personal care, including hygiene care and grooming, on a daily basis.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection for five of five residents with a history of unrelated non-

compliance. (633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 01, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Order / Ordre :

The licensee shall ensure that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations and
appropriate action is taken in response to every such incident.

Specifically, the licensee shall ensure that:
• All staff are educated on the written policy to promote zero tolerance of abuse and neglect of residents; including mandatory reporting, roles and responsibilities, the process for investigating abuse and neglect and the immediate and long term appropriate actions to be taken;
• The Administrator, the Director of Care, and all other management staff of the home are educated on the process for investigating abuse and neglect, roles and responsibilities, mandatory reporting, as well as immediate and long term appropriate actions to be taken;
• There is a process developed and implemented for documenting and maintaining investigation records.
• There is a process for monitoring and tracking staff education to ensure all processes are completed and implemented.

Grounds / Motifs :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of neglect of a resident that the licensee knows of, or that was reported to the licensee was investigated immediately and appropriate action was taken in response to every such incident and the licensee failed to report to the Director the results of every investigation.

"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.

A resident's family member indicated that they observed the resident was found sitting slouched in a chair with fluids and food on their clothing. The family shared that the DON was standing with nursing staff with her back to the resident when the family told the DON that there were concerns about the resident's appearance. Later that day, the family member again observed the resident's clothing was wet with fluids.

A photograph of the resident showed the resident in a chair slouched to the right side and leaning forward. There were no interventions in place to support the resident's posture and to provide comfort. There also appeared to be a large dark spot on the resident's anterior upper clothing. Another photograph showed the resident sitting upright wearing clean dry clothing with an intervention in place to provide support and comfort one hour later. Another photograph taken, approximately three hours later, showed the resident was soaked with fluid on the resident's clothing and the resident was slouched and leaning to the right.

The Director of Nursing (DON) shared that they overheard a family member tell another person about the allegations of neglect related tot he resident's care. The DON acknowledged that she heard the allegation of neglect. The DON also shared that the home did not investigate "too much" and staff were not interviewed. There was no documentation to support an investigation occurred and the DON acknowledged that she did not feel this was an incident of neglect and therefore did not investigate.

Interview with Registered Practical Nurse Behavioural Supports Ontario (RPN BSO) indicated that the resident was often "flopped in the chair" and that an OT assessment should have been completed and was not. (633)

The DON shared that the resident usually had an intervention in place to support the resident's posture and to provide comfort. The DON could not recall seeing the intervention in place at the time of the incident.

The acting Administrator shared that it was the home's responsibility to

investigate any suspected or alleged neglect.

The licensee failed to immediately investigate an allegation of neglect of a resident and the home did not take appropriate action in response to this incident. [s. 23.]

2. The Director of Nursing (DON) submitted a Critical Incident System Report to the Ministry of Health and Long-Term Care (MOHLTC) to inform the Director of the alleged neglect of the resident. The family member of a resident submitted a complaint to the MOHLTC that also reported the alleged neglect of the resident.

The resident was to be provided specific interventions during meals. The progress notes in PointClickCare (PCC) verified that the resident sustained an injury during a meal. Observation of the resident's injury verified that the injury was healing, but still remained.

Record review of the Policy and Procedure titled Response to Complaints last reviewed on February 2014 indicated that "all complaints will be documented, investigated and formally responded to promptly utilizing the Report of Complaint form". Record review of the Policy and Procedure titled Abuse & Neglect-Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to staff last reviewed August, 2016 indicated that Mandatory Reporting included the DON "immediately notifying the Administrator of the initiation of an investigation" and that the DON and/or Administrator will interview all parties and maintain a written record using the Abuse-Resident Incident Report".

The Dietary Aide that served the meal to the resident and the Food and Nutrition Manager indicated that neither staff had been interviewed by management related to the resident's injury and the Food and Nutrition Manager was not aware that the incident had occurred at all.

The DON and record review of the Complaint Form that was completed by the DON verified that there was no documentation related to the resident's injury. No other additional documentation was completed and an evaluation was not done as there were no investigative steps taken including no interviews with relevant staff, and no review of one of the home's identified policies last reviewed July 2016. There was no report to the Director (MOHLTC) of the results of the investigation by an amendment to the critical incident report made to the

MOHLTC or otherwise.

Interview with acting Administrator verified that the expectation would be that an investigation should have been done and a report to the Director (MOHLTC) of the results of the investigation should have been made by the DON and submitted to the Director and was not.

The licensee has failed to ensure that the alleged, suspected or witnessed incident of neglect of a resident that was reported to the licensee was investigated and the results of the investigation reported to the Director (MOHLTC).

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. There was a compliance history of this legislation being issued in the home on August 30, 2016 as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2016_326569_0021. (633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 01, 2017

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Order / Ordre :

The licensee shall ensure staff and others who provide direct care to all residents are kept aware of the contents of the plan of care and have convenient and immediate access to it. The licensee shall develop and implement a process for revising the kardex to be consistent with the residents plan of care.

The licensee shall ensure that every resident is reassessed and the plan of care reviewed and revised when the resident's care needs change and the care set out in the plan is no longer effective.

The licensee shall identify which staff are responsible for monitoring and ensuring the plan of care for all residents is reviewed and revised, and staff and others who provide direct care to all residents are kept aware of the contents of the plan of care and have convenient and immediate access.

Grounds / Motifs :

1. s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

The licensee failed to ensure staff and others who provided direct care to a resident, were kept aware of the contents of the plan of care and had convenient and immediate access to it.

A) Record review of the current care plan and kardex documented specific interventions for a resident to address specific behaviours.

The resident was observed by inspectors and specific interventions documented were not followed.

The Registered Practical Nurse shared interventions for care provided by Personal Support Workers (PSWs) were on the kardex or task list and PSWs only access the kardex for care plan interventions.

The RPN Behavioural Supports Ontario (BSO) acknowledged that specific interventions in the current plan of care were not accessible to PSWs and verified that only those interventions that have been dedicated to the kardex were viewed by the PSW staff in Point of Care (POC).

B) Record review of the current care plan and kardex for the resident documented specific interventions related to protective garments, skin care and behaviours.

On specified days the resident was observed before a meal or snack without the use of a protective garment and clothing was soaked with fluid.

The RPN BSO acknowledged the interventions related to the resident were not added to the kardex for PSWs.

The Personal Support Worker (PSW) and the PSW Student clicked the kardex button in Point of Care (POC) and shared that the "Kardex Summary" on POC provided the summary of resident care for PSWs to follow and verified that PSWs did not have access to the care directions in the plan of care.

The licensee failed to ensure staff and others who provided direct care to the residents were kept aware of the contents of the plan of care and had convenient and immediate access to it. LTCHA, 2007, S.O. 2007, c.8, s. 6 (8)

The severity was determined to be a level 3 as there was actual harm/risk. The scope of this issue was widespread during the course of this inspection with a history of unrelated non-compliance.

2. 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).

The licensee has failed to ensure that every resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed and the care set out in the plan was no longer effective.

A) A Critical Incident System Report and Complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) to inform the Director of the alleged neglect of the resident.

Record review of the current care plan indicated that a resident required assistive eating devices at meals.

Record review of the progress notes in PointClickCare (PCC) indicated that the resident was injured during a meal.

The PSW, Nurse's Aide, PSW Student, RPN, RPN BSO, Director of Nursing (DON) verified that registered staff refer to the care plan and PSWs rely on the kardex in PCC to obtain resident care information.

Record review of the care plan and kardex in PCC for a resident verified that specific interventions related to eating assistance were not added to the care plan until several days after the incident.

The RPN, RAI-C, RPN BSO and Director of Nursing (DON) verified the care plan for a resident should have been updated immediately, or sooner than a week or more, and was not.

The licensee has failed to ensure that the plan of care was revised the current plan was no longer effective.

B) Record review of the plan of care in PointClickCare (PCC) indicated that a resident used a specific device for mobility provided by the home and a record review of the progress notes in PCC for the resident indicated several near miss falls, injuries, poor posture and a change in mobility.

Record review of the current care plan in PCC for the resident noted that interventions related to positioning and safety were not documented.

Record review of the Minimum Data Set (MDS) admission, quarterly and annual

assessments in PCC demonstrated that the resident had a change in mobility.

The Occupational Therapy (OT) referral form indicated that a resident required an assessment.

Interview with the OT indicated that the resident had not received OT services for several months and was not prioritized and assessed for positioning and safety.

Registered Practical Nurse Behavioural Supports Ontario (RPN BSO) indicated that a resident had physically and cognitively declined since admission and that an OT assessment should have been completed and was not.

Interview with the RAI-C indicated that care plan reviews were completed quarterly based on the MDS Bedside Assessment Tool completed by the registered staff and that activities of daily living (ADLs) and safety items have the highest priority when checking the care plan for accuracy.

The Personal Support Worker (PSW), Nurse's Aide, PSW Student, RPN, RPN BSO, and Director of Nursing (DON) verified that registered staff referred to the care plan and PSWs rely on the kardex in PCC to obtain resident care information.

C) The licensee failed to ensure a resident was reassessed and the plan of care was reviewed and revised when a resident's care needs changed.

Record review of the current care plan and kardex on for the resident documented there were no interventions related to the use of specific intervention used for posture and support.

Record review of the Minimum Data Set (MDS) assessment documented that the resident had functional limitation in range of motion with partial loss of voluntary movement.

A resident's family member shared they have shown staff how to apply the specific intervention to position a resident safely to reduce the risk of sliding and falling and staff have not complied.

The Registered Practical Nurse (RPN) shared that a resident was often

uncomfortable and was given interventions for support.

The Director of Nursing (DON) shared the resident was physically supported with a specific intervention and shared that staff would know to use the intervention by referring to the care plan or kardex.

The RPN Behavioural Supports Ontario (BSO) acknowledged that there were no interventions in the care plan or kardex related to the use of the specific intervention for positioning and maintenance of posture.

The licensee has failed to ensure that the plan of care was revised when a resident's functional limitation changed.

D) Record review of the current care plan and kardex for a resident stated specific interventions related to behaviours.

Observations of a resident on three separate dates demonstrated the resident did not exhibit these behaviours.

The RPN BSO shared that a resident no longer exhibited specific behaviours. The RPN BSO acknowledged that the interventions were no longer necessary.

The licensee has failed to ensure that the plan of care was revised when care needs changed. LTCHA, 2007, S.O. 2007, c.8, s. 6 (10)

The severity was determined to be a level 3 as there was actual harm/risk. The scope of this issue was widespread during the course of this inspection with a history of unrelated non-compliance. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 01, 2017

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
Ontario, 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
Ontario, 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 24th day of January, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Melanie Northey

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