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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Feb 23, 2016	2015_188168_0031	H-003397-15	Resident Quality Inspection

Licensee/Titulaire de permis

MAPLEWOOD NURSING HOME LIMITED
500 QUEENSWAY WEST SIMCOE ON N3Y 4R4

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

CEDARWOOD VILLAGE
500 QUEENSWAY WEST SIMCOE ON N3Y 4R4

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

LISA VINK (168), CAROL POLCZ (156), LESLEY EDWARDS (506), MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 19, 20, 21, 22, 23, 26, 27, 28, 29, 30, 2015.

During this inspection the inspections listed below were conducted concurrently:

Complaints
Complaint H-001403-14 - related to non allowable charges, was not fully inspected during this RQI and will be inspected at a later date.
H-001741-14 - related to skin and wound care, the administration of medications and residents' rights.
H-001596-14 - related to abuse and responsive behaviours.
H-001193-14 - related to nursing and personal support services.
H-001330-14 - related to nursing and personal support services.
H-003387-15 - related to qualifications of personal support workers.
H-002966-15 - related to nursing and personal support services.
H-003059-15 - related to plan of care.
H-001444-14 - related to infection prevention and control, housekeeping, nutrition and hydration, availability of supplies, plan of care and duty to protect.
Critical Incident Reports
H-003436-15 - related to falls management and reporting certain matters to the Director.
H-002855-15 - related to abuse and reporting certain matters to the Director.
H-001388-14 - related to reporting certain matters to the Director and responsive behaviours.
CIATT-30085-15 - related to abuse and residents' rights.
Follow Up
To order #001 from 2015-214146-0009, June 24, 2015, which was the subject of a Directors Review dated July 30, 2015, pursuant to LTCHA, 2007, S.O. 2007, c. 8, s, 19(1) - related to duty to protect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), registered nursing staff, personal support workers (PSW's), office manager, physiotherapist, maintenance staff, Food Services Manager (FSM), hairdresser, programs manager, dietary staff, families and residents.

During the course of the inspection the inspectors toured the home, observed the provision of care and services, reviewed relevant records including meeting minutes, policies and procedures and resident health records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **17 WN(s)**
- **12 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

s. 6. (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).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for each resident set out the planned care for the resident.

A. The Medication Administration Record (MAR) did not provide direction for staff regarding the planned care for resident #052. Progress notes identified that in November

2014, the resident had challenges taking their prescribed medications and as a result staff began to crush the medications to ensure ingestion, when required. The resident's representative felt that the practice of crushing medications was not necessary, voiced this concern to a number of registered staff and asked that it be discontinued. A progress note written in January 2015, identified that the DOC had a discussion with the representative and directed staff to attempt to administer the medications without being crushed (or to get a physician's order to crush them) if the resident was unable to swallow them. Interview with registered staff #110, #107 and #111 verified that direction regarding medication administration would be recorded on the MARs. Registered staff #111 reviewed the resident's MAR for December 2014 and January 2015 and confirmed that there was no direction regarding the planned care for the resident related to the administration of their medications.

B. Resident #013 was observed to use a front fastening seat belt. A review of the plan of care did not include the presence of the belt. Registered staff #107 confirmed on October 28, 2015, that the seat belt, which was used as a PASD, should be included in the plan of care and that this was not currently recorded as part of the planned care. (156)

C. Resident #050 had a history of responsive behaviours and was readmitted to the home in 2015. The plan of care in place at the time of the inspection was reviewed and did not include all of the planned care for the resident's behaviours. Staff interviewed were aware of the need for frequent monitoring, room checks and the potential for the escalation of behaviours in the dining room; however, the plan of care did not address these issues until identified by the inspector on October 29, 2015, which was confirmed by registered staff #107. (168)

D. Resident #021 sustained a fall in October 2015, which resulted in transport to hospital for an assessment and the application of a device due to an injury. Staff completed additional assessments due to the presence of the device as identified in the progress notes. A review of the plan of care did not include the presence of the device following its application. Interviews with registered staff #107 and #109 confirmed that they did not include the information regarding use of the device in the resident's plan of care and registered staff #107 confirmed that this planned care was not included in the plan during a record review. (168) [s. 6. (1) (a)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their

assessments were integrated, consistent with and complemented each other.

The Resident Assessment Protocols dated April 3, 2015 and July 3, 2015 indicated that resident #013 experienced pain daily; however, the October 20, 2015, assessment indicated that the pain had decreased to less than daily. Review of the clinical record and interview with registered staff #107 confirmed that the resident still experienced pain on a daily basis and their pain had not decreased; the assessment of the resident's pain was not integrated and consistent with the clinical record and interview with staff. [s. 6. (4) (a)]

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

The clinical record identified that resident #040 was to have MedPass 2.0, 60 milliliters (mls) twice a day at breakfast and supper as ordered by the registered dietitian on June 3, 2015. This order was included in the plan of care; however, was not transcribed to the physician's orders sheet or MAR and therefore was not administered to the resident as ordered. This omission was confirmed in the clinical record and during interview with registered staff #110. [s. 6. (7)]

4. The licensee failed to ensure that staff and others who provided direct care to residents were kept aware of the contents of their plans of care.

On an identified date in October 2015, it was identified that three shared resident rooms had signage for contact precautions on the outside of their doors. Interview with registered staff #100 identified they were unaware of which residents were on contact precautions or where to find this information in the plans of care and suggested that registered staff #111 would be able to provide the information. Interview with registered staff #111 identified that they were not able to identify which residents were on contact precautions in the identified rooms. PSW #123 was interviewed and they were not able to correctly identify which residents were to be on contact precautions. Three staff were not aware of the contents of the resident's plans of care. [s. 6. (8)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A. The plan of care for resident #016 identified that staff were not to leave the resident

on the toilet unattended; they were to use a seat belt to help keep the resident seated during elimination. Interview with nursing staff #104 on October 21, 2015, confirmed that the resident no longer required the seat belt during elimination due to a change in needs. The plan of care was not revised and reviewed when the resident's care needs changed or care set out in the plan was no longer necessary related to the use of the seat belt. (156)

B. Resident #013 had a table top restraint ordered in August 2015. During an interview on October 26, 2015, the resident reported that they would like the restraint removed so that they could walk. The resident was observed to walk with the assistance of PSW #123 holding onto her arm. The staff reported that the resident had improved recently and was able to walk with assistance. The current plan of care indicated that the resident was on a walking program; however, the resident and PSW #123 verified that this was not current, that they were no longer on the program. Interview with the physiotherapist on October 27, 2015, identified that the resident was not on the walking program since February 2015, due to achieving the identified goals. Since February 2015, the resident had a decline and began to use the wheelchair as their primary source of mobility; however, had recently had an improvement in condition. Registered staff #107 and #100 reported that the resident was doing much better and that their care needs had changed. On October 26, 2015, the resident was reassessed and the table top was removed. The resident's care needs had changed with regards to the need for the table top and the resident had not been reassessed. (156)

C. Resident #031 had seven documented incidents of responsive behaviours or altercations involving co-residents and staff during a 18 day time period in May 2015; however, the plan of care was not reviewed and revised when the resident's care needs changed and the interventions in place to manage the responsive behaviours were not effective. Registered staff #108 confirmed that the plan of care should have been reviewed and revised when the resident's care needs changed related to the increase in response behaviours. (506)

D. Resident #040, who no longer resided in the home, was assessed on admission in May, 2015 as requiring 1275-1700 mls fluid daily. According to the Dietary Report on daily fluid intake, the resident did not meet their daily requirements for 26 days in June 2015, 29 days in July 2015 and each day that they were in the home in August 2015. Review of the clinical record and interview with the DOC on October 29, 2015, confirmed that the resident was not referred to the registered dietitian and was not reassessed when their care needs changed related to hydration. (156) [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care for each resident sets out the planned care for the resident; that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other and that staff and others who provide direct care to residents are kept aware of the contents of their plans of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was protected from abuse.

A. In 2014, resident #034 was admitted to the home to a shared room with resident #033. Resident #033 had a history of responsive behaviours and was known to be territorial with their belongings. Three days after admission resident #034 entered their roommate's side of the room to pull the curtains which agitated the co-resident. Resident #033 grabbed resident #034 and caused a bruise and skin tear. Staff heard the altercation, intervened and separated the two residents. Resident #034 was taken to the nursing station as they were upset and afraid to return to their room. The resident was not protected from abuse.

B. The licensee was served an order under inspection 2015-214146-0009, on June 24, 2015, for failure to comply with section 19 (1) of the LTCHA, 2007, duty to protect. This

order was the subject of a Director's Review and as a result the order served on June 24, 2015, was substituted with a Director's Order as identified below and dated July 30, 2015:
Pursuant to LTCHA, 2007, S.O. 2007, c.8, s. 19(1):
Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.
Order:
The licensee will protect residents from abuse by anyone, including other residents, specifically resident #001. The home will immediately create and implement strategies to protect residents from abuse by resident #001 including but not limited to annual training of staff as required by the LTCHA and Regulation, consistent monitoring of the resident, regular room checks for items which could potentially be used to harm others, the implementation of any other interventions identified for resident #001 and utilize outside resources to assist in the management of cognitively impaired residents with responsive behaviours. In addition the licensee is to review their Abuse and Neglect policy, dated March 18, 2014, against the legislated requirements in the LTCHA and the Regulation. They are to update the policy to ensure it meets the requirements and then ensure staff receive training on the newly updated policy. The order was to be complied with by September 30, 2015.

i. The licensee failed to comply with the order when they did not provide training to staff on the newly updated Abuse and Neglect policy by September 30, 2015. Interview with the Administrator confirmed that the home placed an emphasis on the completion of the abuse modules in their Surge learning program; however, that this program nor the specific modules was specific to the home's policy or the changes made to the policy. It was confirmed that staff were not provided training on the home's newly updated abuse policy as required in the order. (168)
ii. Resident #050, who was previously identified as resident #001 during inspection 2015 -214146-0009, had a history of responsive behaviors, which included physical aggression towards co-residents. The responsive behaviours of the resident were previously inspected by the Ministry of Health and Long-Term Care due to an injury caused to a co-resident and a compliance order was served related to duty to protect. A review of the clinical record, since the time of the previous inspection, identified that in July 2015, the physician wrote an order to "continue present one-to-one and all measures to prevent the resident from harming self or other". Thirteen days later, the physician's order identified that the home was to continue with one-to-one for the resident.
Registered staff #108 confirmed that the resident was provided one-to-one supervision

by PSW's on the day and evening shifts; however, that there were occasions when they could not fill the shifts and at that those times staff were directed to complete every 15 minute checks of the resident, in an effort to ensure safety.
During the time frame of July 6, 2015 until August 10, 2015, the resident was not consistently provided one-to-one supervision as per their care needs, as ordered by the physician to prevent harm to self or others, on fifteen separate occasions as confirmed by registered staff #108.
On a specified shift where one-to-one was not provided as required, the resident demonstrated behaviours which were deemed to be a threat to self or others and additional resources, from an outside agency were called in immediately to assist in the management of the situation. The home did not ensure that identified measures, which were an assessed need for the resident, were consistently in place to protect others from abuse. (123) [s. 19. (1)]

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. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (1) A licensee shall not charge a resident for anything, except in accordance with the following:
1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
2. For preferred accommodation, a resident shall not be charged more than can be charged for basic accommodation in accordance with paragraph 1 unless the preferred accommodation was provided under an agreement, in which case the resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
3. For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount. 2007, c. 8, s. 91 (1).
4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for. 2007, c. 8, s. 91 (1).

s. 91. (4) A licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf. 2007, c. 8, s. 91. (4).

Findings/Faits saillants :

1. The licensee charged a resident for anything, despite paragraph 3, that the regulations provide was not to be charged for.

Ontario Regulation 79/10 section 245 paragraph 1 identified the following:
"The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act: 1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from, i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and ii. the Minister under section 90 of the Act".

The licensee received funding from the local health integration network under section 19

of the Local Health System Integration Act, 2006, for goods and services funded by the local health integration network under their service accountability agreement for continence care supplies.

The Long Term Care Home (LTCH) Policy, LTCH Required Goods, Equipment, Supplies and Services, dated July 1, 2010, identified that:
"The licensee must provide the following goods, equipment, supplies and services to long-term care (LTC) home residents at no charge, other than the accommodation charge payable under the Long-Term Care Homes Act, 2007 (LTCHA), using the funding the licensee receives from the Local Health Integration Network under the Local Health System Integration Act, 2006 (LHSIA) or the Minister under the LTCHA or accommodation charges received under the LTCHA.
2.1 Required Goods, Equipment, Supplies and Equipment
2.1.2 Continence Management Supplies
Continence management supplies including, but not limited to:
a. A range of continence care products in accordance with section 51 of the Regulation under the LTCHA".

Section 51(2) of the Regulation under the LTCHA identified the following:
"51. (2) Every licensee of a long-term care home shall ensure that, (f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; and (h) residents are provided with a range of continence care products that, (i) are based on their individual assessed needs, (ii) properly fit the residents, (iii) promote resident comfort, ease of use, dignity and good skin integrity, (iv) promote continued independence wherever possible, and (v) are appropriate for the time of day, and for the individual resident's type of incontinence".
If a resident was assessed to require a pull up style incontinent product than it shall be provided as part of the range of continence care products to be provided at no charge by the home.

The licensee charge a resident for continence care products that the regulations indicated was not to be charged for.

A. The plan of care for resident #017 identified that they were independent with set up assistance for toileting and used a pull up style incontinent product. A progress note dated October 1, 2015, noted that the PSW reported that the resident usually toileted independently and continued to use the pull up program. A review of the resident's Statement of Account dated August 31, 2015, included a charge of $44.84 for incontinent

products. Discussion with registered staff #107 confirmed that the resident wore a pull up style incontinent product which was ordered by the home; however, charged to the resident's family.

B. Family of resident #053 identified that until a recent injury in October 2015, the resident required little assistance with their activities of daily living, including toileting. The plan of care identified that the resident was toileted with limited assistance of one staff. A review of the resident's Statements of Accounts dated September 30, 2015, August 30, 2015 and July 31, 2015, each included a charge of $46.08 for incontinent products. Discussion with registered staff #107 confirmed that the resident wore a pull up style incontinent product which was ordered by the home; however, charged to the resident's family.

C. A review of resident #054 Statements of Accounts dated September 30, 2015, August 30, 2015 and July 31, 2015, each included a charge of $46.08 for incontinent products. Discussion with registered staff #107 confirmed that the resident wore a pull up style incontinent product which was ordered by the home; however, charged to the resident's family.

Interviews with the registered staff #107 and #108 confirmed that the home ordered and provided pull up style incontinent products for residents with the consent of their families; however, that they were billed for these products as the home did not supply them. [s. 91. (1) 4.]

2. The licensee failed to ensure that they did not cause or permit anyone to make a charge or accept such a payment on the licensee’s behalf.

Ontario Regulation 79/10 section 245 paragraph 1 identified the following:
"The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act: 1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from, i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and ii. the Minister under section 90 of the Act".

The licensee received funding from the local health integration network under section 19 of the Local Health System Integration Act, 2006, for goods and services funded by the local health integration network under their service accountability agreement for

continence care supplies.

The Long Term Care Home (LTCH) Policy, LTCH Required Goods, Equipment, Supplies and Services, dated July 1, 2010, identified that:
"The licensee must provide the following goods, equipment, supplies and services to long-term care (LTC) home residents at no charge, other than the accommodation charge payable under the Long-Term Care Homes Act, 2007 (LTCHA), using the funding the licensee receives from the Local Health Integration Network under the Local Health System Integration Act, 2006 (LHSIA) or the Minister under the LTCHA or accommodation charges received under the LTCHA.
2.1 Required Goods, Equipment, Supplies and Equipment
2.1.2 Continence Management Supplies
Continence management supplies including, but not limited to:
a. A range of continence care products in accordance with section 51 of the Regulation under the LTCHA".

Section 51(2) of the Regulation under the LTCHA identified the following:
"51. (2) Every licensee of a long-term care home shall ensure that, (f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; and (h) residents are provided with a range of continence care products that, (i) are based on their individual assessed needs, (ii) properly fit the residents, (iii) promote resident comfort, ease of use, dignity and good skin integrity, (iv) promote continued independence wherever possible, and (v) are appropriate for the time of day, and for the individual resident’s type of incontinence".
If a resident was assessed to require a pull up style incontinent product than it shall be provided as part of the range of continence care products to be provided at no charge by the home.

The licensee permitted the resident's representative to make a charge or accept a payment on the licensee’s behalf for continence care products, which they received funding from the local health integration network under their service accountability agreement.

A review of the plan of care for resident #024 identified that they used a pull up style incontinent product. A progress note, written June 8, 2015, noted that the resident continued to be incontinent of urine and did not recognize the need to go to the bathroom, before incontinence occurred. It identified that the resident "may be better suited for a pull up" and requested that staff call the resident's family to see if this could

be arranged. A follow up note was completed on June 29, 2015, which noted that the family was in and identified that the resident dribbled urine and questioned if a brief style incontinent product would be better for the resident. The staff member suggested a trial of pull ups, which the family agreed to purchase and bring them in and if successful would order through the home. Interview with registered staff #102 verified that the family provided the incontinent product for the resident as they were able to get them for a better price than the home could provide. [s. 91. (4)]

Additional Required Actions:

CO # - 003, 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 they do not cause or permit anyone to make a charge or accept such a payment on the licensee's behalf, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the rights of residents were fully respected and promoted specifically to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On October 19, 2015, the noon medication pass was observed. The garbage of the medication cart was noted to have opened medication pouches which contained resident's names and the names of medications which were included in the pouches. Registered staff #100 was observed administering medications to a number of residents. She confirmed the process of discarding the pouches in to the garbage and identified that it would later be disposed of with the regular garbage. During a discussion she confirmed that the pouches contained resident names as well as the names of prescribed medications and that this information was personal health information and not destroyed in a similar fashion as other personal health information. The right of residents to have their personal health information kept confidential was not fully respected or promoted. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the rights of residents are fully respected and promoted specifically to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, 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.

A. The home's program, Continence Care and Bowel Management, NDM-III-240, dated November 20, 2011, identified that:
"Registered Nursing Staff:
1. Collaborate with resident/Substitute Decision Maker (SDM) and family and interdisciplinary team to conduct a bowel and bladder continence assessment utilizing a clinically appropriate instrument (Appendix A: Bladder and Bowel Continence Assessment), on admission, quarterly (according to the RAI-MDS 2.0 schedule) and after any change in condition that may affect bladder or bowel continence.
3. Initiate a voiding monitoring record that includes fluid intake, urine voided, incontinence episodes. Complete for a 7 day period to establish the resident's individual

voiding pattern and monitor trends (Appendix B: Bladder Monitoring Record).
4. Initiate a bowel monitoring record that includes consistency, size and incontinence episodes. Complete for a 7 day period to establish the resident's individual bowel pattern and monitor trends (Appendix C: Bowel Monitoring Record)".

i. Resident #024 was admitted to the home in April 2015. A review of the clinical record included a Bladder and Bowel Continence Assessment on admission; however, did not include Bladder or Bowel Monitoring Records. The resident had a change in continence, a deterioration, according to the Minimum Data Set (MDS) assessment completed on July 17, 2015; however, the clinical record did not include a Bladder and Bowel Continence Assessment nor Bladder or Bowel Monitoring Records, as confirmed during interviews with registered staff #107 and #111 as required according to the program. (168)
ii. Resident #014 had a significant change of status on June 23, 2015, which included a change in the resident's continence care. Prior to the change the resident toileted independently and did not require continence care products. After June 23, 2015, the resident required assistance for all aspects of toileting and used continence care products. Registered staff #108 confirmed that the Bladder and Bowel Continence Assessment nor Bladder Monitoring Records, were not completed and that the home did not follow their policy. (506)

B. The home's procedure Responsibility for LOA/Documentation, NDM-III-205, dated June 2005, identified the following when a resident was on a leave of absence (LOA): "2. If medication to accompany, prepare and have signed by responsible person "Acceptance of Responsibility to Resident During Leave and for Medications".

A review of the available clinical records identified that resident #052 took frequent casual LOA's. The records indicated that the resident was on leave approximately 20 times over a 31 day period. The clinical record included only ten Acceptance of Responsibility to Resident During Leave and for Medications forms completed. Staff did not consistently prepare or have the responsible person sign the Acceptance of Responsibility to Resident During Leave and for Medications form during each leave when medications accompanied the resident on the leave. Interview with registered staff #108, #112, #113 and #119 verified that initially when the resident was going on LOA the medications would be sent with the responsible party without signing the Acceptance of Responsibility to Resident During Leave and for Medications form. The responsible party would sign the resident out using the Release of Responsibility for Leave of Absence form only. The home's policy was not complied with. (168)

C. The home's program Pain Management, NDM-111-410, dated September 7, 2011, identified that registered nursing staff would "collaborate with resident/resident's representative, family and interdisciplinary team to conduct the pain assessment utilizing a clinically appropriate instrument (Appendix B: Pain Assessment Tool) within 24 hours of admission, quarterly (according to the RAI-MDS schedule) and when a resident exhibits a change in health status or pain is not relieved by initial interventions".

Interview with resident #012 and a review of the clinical record identified the presence of pain and interventions in place, including narcotics. The resident was admitted to the home in 2011. A review of the clinical record included the completion of only two formalized pain assessment tools, one on admission and the second in August 2015, as verified with registered staff #109 and #111. A review of the progress notes and MARs identified that the resident had reports of pain and received treatment to manage on ten occasions in both May and June 2015, on two occasions in both July and August 2015, on eight occasions in September 2015 and three occasions to date in October 2015. The resident was not assessed as required according to the home's program as confirmed during an interview with registered staff #109.

D. The home had a system in place to weigh each resident at least monthly. This task was completed by front line nursing staff and recorded on a document which included the weights of multiple residents, for each floor, for the identified month. This information was then recorded in each resident's electronic clinical record, as confirmed by registered staff #107. Residents #053 and #041 did not have a monthly weight taken and recorded for the month of July, 2015 as confirmed with registered staff #107 on October 29, 2015. The system in place was not consistently complied with. (156) [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #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 failed to ensure that where bed rails were used the resident had been assessed to minimize risk to the resident.

The plan of care for resident #012 identified that they used one bed rail in the raised position when in bed, which was consistent with MDS assessments and staff interview. A review of the clinical record did not include an assessment of the resident for the use of the bed rails as confirmed during a record review with registered staff #107. Discussion with registered staff #108 confirmed that the home had a procedure to assess each resident with bed rails with the Bed Rail Risk Assessment tool to minimize risk; however, that such an assessment could not be located. [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 are used the resident is assessed to minimize risk, 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 failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy Abuse and Neglect, ADM-II-245, dated August 29, 2015, identified under reporting an incident, that all staff, volunteers, service providers and affiliate personnel were required to: "Immediately report to the supervisor (e.g. Charge Nurse) in the home on duty at the time of a witnessed or alleged incident of abuse or neglect" and identified management "staff must investigate immediately all reports of abuse or neglect, in accordance with the investigation procedures set out in the document LTCHA Regulation s. 23(1)".

A. A review of progress notes for resident #052 included documentation of a report of a PSW being "too rough" with care on an identified shift in December 2014. Registered staff #112, who was informed of the allegation by the resident, had no recall of the discussion at the time of this inspection. The staff confirmed that she documented the identified note and that based on the information recorded no action was taken as a result, including reporting the incident.
She confirmed that she had received training on prevention of abuse at the home.
Interview with the DOC identified that she was unaware of the incident until October 26, 2015 and confirmed the expectation that this type of allegation be reported and investigated as per the home's policy.

B. A review of progress notes for residents #017 and #013 included documentation of an incident between the two residents in July 2015. Resident #017 reported that they were touched inappropriately by resident #013 and was propositioned for physical contact. This interaction was unwanted by resident #017 who reportedly told the co-resident "no".
Interview with registered staff #117, who was informed of the interaction by resident #017 confirmed some recollection of the story as relayed by the resident. She identified that as a result of the resident's statement she recorded the incident as described by the

resident and monitored the residents; however, confirmed that she did not report the incident as required.
The staff member confirmed that she had received training on prevention of abuse at the home.
Interview with the DOC identified that she was unaware of the incident until October 27, 2015 and confirmed the expectation that this type of allegation be reported and investigated as per the home's policy.

C. During an interview resident #056 reported that they communicated to staff that they were upset about the way that they were treated by a identified staff member and sustained an injury due to the care they received in October 2015. PSW #123 was interviewed and confirmed that the resident reported alleged verbal abuse, that they were upset when they recounted their story and sought advise as to whether they should report their concerns. The PSW identified that she told the resident that the decision to report or not was up to the resident. PSW #123 confirmed that she did not report the alleged verbal abuse of resident #056 as required. The resident reported the incident to the DOC at which time an investigation was initiated. (123) [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 the written policy to promote zero tolerance of abuse and neglect of residents 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. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A. The home had a monthly restraint and observation form which nursing staff were expected to sign every hour that they had visually checked the resident for comfort, positioning and that the restraint was appropriately applied. Restraint records for resident #018 were reviewed and identified to be incomplete specifically for:
i. September 2015 - there were 21 shifts where the nursing staff failed to document from days and evenings on the wheelchair table top restraint and 20 shifts where staff did not complete the form on days and evenings for the lap belt restraint;
ii. October 2015 - there were 13 shifts where the nursing staff failed to document from days and evenings on the wheelchair table top restraint and 12 shifts where staff did not complete the form on days and evenings for the lap belt restraint. This information was confirmed by registered staff #108. (506)

B. Resident #021 sustained a fall and was transferred to the hospital the same day where a device was applied. When the resident was readmitted to the home the staff documented the new diagnosis, a follow up appointment and some of the care provided. The readmission notes did not include the presence of the device nor the assessment conducted of the resident related to the application of the treatment or injury. Interview with registered staff #118 confirmed that she was aware of the device and conducted an assessment; however, verified after a reading of the progress notes that her assessment and findings were not documented in the clinical record as required. (168)

C. Resident #050 was transferred from the home in August 2015. A review of the clinical record did not include any assessment or interventions completed at the time that the resident was transferred from the home. Interview with registered staff #108 confirmed that staff would have completed assessments and care at the time of the transfer, that this information should have been recorded and was not completed. (168)

D. According to a progress note for resident #050, an incident occurred between the resident and resident #060 in October 2015. This incident required an assessment of resident #060 to rule out any injury. A review of the clinical record for resident #060 did not include any notation of the incident, assessment or the response of this resident, as confirmed during an interview with registered staff #102 who conducted the assessment. (168)

E. Resident #050 had a history of responsive behaviours. According to the progress notes on an identified date in July 2015, the resident was administered a medication for agitation which was prescribed on an as needed basis. This medication was noted to be effective in the clinical record a few hours later. A review of the record did not include the assessment of the resident at the time that the medication was administered or any information about the specific actions of the resident which resulted in its administration. Interview with registered staff #124, who administrated the medication, confirmed following a review of the clinical record that she did not document her assessment of the resident or the behaviours and that this should have been recorded. A review of the record included no narrative Point of Care documentation for the resident on the identified date in July 2015. (168) [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every restrained resident in the home restrained by the use of a physical device, was done so other than in accordance with section 31 or under the common law duty described in section 36.

Resident #013 was observed with a table top restraint on their wheelchair on October 23 and 26, 2015. The table top was included in the plan of care; however, as per section 31 of the Act, the resident may only be restrained if alternatives to restraining had been considered and tried where appropriate but were not effective to address the risk. A review of the resident's clinical record as well as confirmation by registered staff #107, #109 and #100 confirmed that alternatives to the use of the table top restraint were not tried. [s. 30. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every restrained resident in the home is restrained by the use of a physical device, in accordance with section 31 or under the common law duty described in section 36, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 36. Common law duty

Specifically failed to comply with the following:

s. 36. (2) If a resident is being restrained by a physical device pursuant to the common law duty described in subsection (1), the licensee shall ensure that the device is used in accordance with any requirements provided for in the regulations and that any other requirements provided for in the regulations are satisfied. 2007, c. 8, s. 36. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident was being restrained by a physical device pursuant to the common law duty the licensee ensured that the device was used in accordance with all requirements provided for in the regulations and that all other requirements provided for in the regulations were satisfied.

The clinical record of resident #013 noted the use of a table top restraint on the wheelchair on an identified date in June 2015. On October 28, 2015, registered staff #100 confirmed that the use of the table top was in response to an emergency situation to prevent falling out of the chair. The record also noted the use of a table top restraint on an identified date in July 2015. Interview with registered staff #117 confirmed that the application was done in response to an emergency situation for safety and prevention of falls. Regulation 110 (4) identified that following the application of a physical device pursuant to the common law duty, the licensee shall explain to the residents, or the resident's SDM, the reason for the use of the physical device. Registered staff #100 confirmed that on the date in June 2015 and registered staff #117 confirmed that on the identified July 2015, date these required discussions regarding the need for the device did not occur. [s. 36. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident is restrained by a physical device pursuant to the common law duty the licensee ensures that the device is used in accordance with all requirements provided for in the regulations and that all other requirements provided for in the regulations are satisfied, to be implemented voluntarily.

WN #11: 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,
(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; O. Reg. 79/10, s. 50 (2).

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 the resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, upon any return of the resident from hospital.

A. Resident #012 was admitted to the hospital and discharged back to the home five days later in March 2015. The resident had a history of altered skin integrity. A review of the clinical record did not include a skin assessment on readmission to the home. The need to conduct and document a head to toe skin assessment of the resident was verified with registered staff #107 and #111 who also confirmed that the assessment was not documented as required. (168)

B. Resident #052 was admitted to the hospital in December 2014 and readmitted back

to the home four days later. A review of the clinical record included a skin assessment completed the day the resident returned from the hospital. This assessment was completed by a PSW as identified by registered staff #108 and signed by the physician a few days later. The clinical record did not include a documented skin assessment conducted by registered staff, on readmission, as confirmed during a record review by registered staff #112 who was working at the time when the resident returned to the home. (168) [s. 50. (2) (a) (ii)]

2. The licensee failed to ensure that the resident with altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff.

A. Resident #025 was observed with altered skin integrity. The resident's altered skin was not assessed by a member of the nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, as confirmed by registered staff #109 on October 27, 2015. (156)

B. Resident #012 had a history of altered skin integrity. According to the progress notes the resident had two small open areas identified on October 20, 2015. A review of the wound care binder and interviews with registered staff #109 and #102 confirmed that these areas were new and that an assessment of these areas was not completed using a clinically appropriate assessment instrument as required. (168) [s. 50. (2) (b) (i)]

3. The licensee failed to ensure that the resident with altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home and any changes made to the plan of care related to nutrition and hydration were implemented.

Resident #025 was noted to have altered skin integrity. The resident was not assessed by the registered dietitian with regards to their altered skin integrity as confirmed during a review of the resident's record and interview with registered staff #109 on October 27, 2015. [s. 50. (2) (b) (iii)]

4. The licensee failed to ensure that the resident with altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

A. Resident #025 was noted to have altered skin integrity. The areas were not

reassessed at least weekly by nursing staff as confirmed with registered staff #109 on October 27, 2015. (156)

B. Resident #012 had a history of ulcers. The resident currently had altered skin integrity as confirmed in the clinical record and resident and staff interviews. A review of the record did not include a reassessment of the areas of altered skin integrity at least weekly by a member of the registered nursing staff. The resident had dressings applied to the area prior to April 2015 until present. The clinical record reviewed included reassessments of the area completed at the frequency of approximately every two weeks during the identified time period. Interview with registered staff #109 confirmed that the area was not reassessed weekly as required. (168) [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff, upon any return of the resident from hospital; receives a skin assessment by a member of the registered nursing staff; is assessed by a registered dietitian who is a member of the staff of the home and any changes made to the plan of care related to nutrition and hydration are implemented and is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that the Residents' Council was responded to in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A review of the Residents' Council Meeting Minutes and interviews with the Council President and programs manager confirmed that not all concerns or recommendations were responded to in writing, to the Council, within 10 days of receipt.
A review of Meeting Minutes did not include written responses for the following concerns identified:
i. During the January 23, 2015, meeting concerns/recommendations were raised related to the main dining room being cold and complaints of ants in the dining room. The minutes for the following meeting held February 20, 2015, did not include a response to the issues identified.
ii. During the February 20, 2015, meeting concerns/recommendations were raised related to working short. The minutes for the following meeting March 27, 2015, did not include a response to the issue identified.
iii. During the March 27, 2015, meeting a concern was raised related to what time breakfast was to be served as the residents were waiting for breakfast. The minutes for the following meeting held April 24, 2015, did not include a response to the issue identified.
iv. During the April 24, 2015, meeting concerns were raised related to working short and the stress for everyone involved and concerns that the newly waxed floors were slippery. The minutes for the following meeting held June 26, 2015, did not include a response to the issues identified.
v. During the June 26, 2015, meeting a concern was raised to when the windows would be cleaned. The minutes for the following meeting held July 24, 2015, did not include a response to the issue identified.
vi. During the July 24, 2015, meeting concerns were raised related to staff taking a long time to answer call bells and a request to have their beds made. The minutes for the following meeting held August 21, 2015, did not include a response to the issues identified; however, noted that issues were ongoing.
vii. During the August 21, 2015 and September 25, 2015 meetings the same concerns that were brought forth in July 2015 meeting were re-stated, that the call bells were not being answered promptly and regarding bed making.
It was confirmed by the program manager that the responses to concerns were not consistently being completed within 10 days. [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Residents' Council ares responded to in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. The licensee failed to ensure that prohibited devices were not used in the home specifically any device to restrain a resident to a toilet or commode.

A. The toilet in resident #022's bathroom was noted to have a front fastening seat belt attached to the grab bars. PSW #106 reported that the seat belt was applied to the resident when on the toilet. Staff reported that the resident was unable to release the seat belt.

B. The commode in resident #016's bathroom was noted to have a front fastening seat belt attached. PSW's #104 and #103 reported that the seat belt was used for the resident when on the commode; however, its use had been recently discontinued. Both staff confirmed that the resident was unable to release the belt. The plan of care for resident #016 indicated that staff were not to leave the resident on the toilet unattended and were instructed to fasten the seat belt to help keep them seated during elimination.

The DOC confirmed on October 21, 2015, that seat belts to restrain any resident while on a commode or toilet were not to be used. [s. 112. 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 prohibited devices are not used in the home specifically any device to restrain a resident to a toilet or commode, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who had fallen had a post fall assessment completed using a clinically appropriate assessment instrument that was specifically designed for falls.

In October 2015, resident #030 had an unwitnessed fall with injury, which resulted in a transfer to the hospital. A review of progress notes included a description of the event and the assessment of the resident with documentation of the injuries. The clinical record did not include a post fall assessment using a clinically appropriate assessment instrument. Interview with registered staff #107 confirmed that the resident did not receive a post fall assessment using a clinically appropriate assessment. [s. 49. (2)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council.

A review of the Residents' Council Meeting Minutes confirmed that the meal and snack times were not reviewed during the council meetings. The FSM confirmed on October 19, 2015, that the meal and snack times were not reviewed as part of the Residents' Council meetings. [s. 73. (1) 2.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of an incident no later than one business day after the occurrence of the incident, followed by a report for an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Resident #030 sustained an injury post fall and was transferred to the hospital in 2015. The resident passed away at the hospital three days later. The Director was not notified of the incident until nine days after their death according the the Critical Incident Report. [s. 107. (3.1)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

The home's policy Infection Control Protocols Standards Universal Precautions, ICM-VII-040, dated March 16, 2009, detailed that staff were to follow universal precautions for hand hygiene including before preparing, handling, serving or eating food and before feeding a resident.

On October 19, 2015, during the noon meal observation on second floor, a PSW was observed clearing dirty dishes from the table, then served food and provided assistance with feeding the residents without washing or sanitizing their hands in between. The staff did not comply with the home's policy. [s. 229. (4)]

Issued on this 24th day of February, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA VINK (168), CAROL POLCZ (156), LESLEY EDWARDS (506), MELODY GRAY (123)
Inspection No. / No de l'inspection :	2015_188168_0031
Log No. / Registre no:	H-003397-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 23, 2016
Licensee / Titulaire de permis :	MAPLEWOOD NURSING HOME LIMITED 500 QUEENSWAY WEST, SIMCOE, ON, N3Y-4R4
LTC Home / Foyer de SLD :	CEDARWOOD VILLAGE 500 QUEENSWAY WEST, SIMCOE, ON, N3Y-4R4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	WALTER SGUAZZIN

To MAPLEWOOD NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all residents are reassessed and their plans of care reviewed and revised at any time when, the resident's care needs change or care set out in the plan is no longer necessary related to restraint usage and nutrition and hydration needs.

The licensee shall:
A. provide education to front line staff regarding the importance of communicating changes in resident care needs to registered staff, when they are identified, so that the resident is reassessed when appropriate
B. provide direction to all registered staff regarding their roles and responsibilities in relation to the assessment and care planning of residents in a timely fashion
C. conduct auditing activities at a schedule and frequency as determined by the licensee to ensure that staff are assessing residents related to the need for restraining and nutrition and hydration needs as required.

Grounds / Motifs :

1. Non compliance related to LTCHA, 2007, section 6(10)b was not previously identified in the past 3 years. The severity of non-compliance related to section 6(10)b was identified at level 2 - minimal harm or potential for actual harm.

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A. Resident #013 had a table top restraint ordered on August 4, 2015. During an interview on October 26, 2015, the resident reported that they would like the restraint removed so that they could walk. The resident was observed to walk with the assistance of PSW #123 holding onto her arm. The staff reported that the resident had improved recently and was able to walk with assistance. The current plan of care indicated that the resident was on a walking program; however, the resident and PSW #123 verified that this was not current, that they were no longer on the program. Interview with the physiotherapist on October 27, 2015, identified that the resident was not on the walking program since February 2015, due to achieving the identified goals. Since February 2015, the resident had a decline and began to use the wheelchair as their primary source of mobility; however, had recently had an improvement in condition. Registered staff #107 and #100 reported that the resident was doing much better and that their care needs had changed. On October 26, 2015, the resident was reassessed and the table top was removed. The resident's care needs had changed with regards to the need for the table top and the resident had not been reassessed. (156)

B. Resident #040, who no longer resided in the home, was assessed on admission in May, 2015 as requiring 1275-1700 mls fluid daily. According to the Dietary Report on daily fluid intake, the resident did not meet their daily requirements for 26 days in June 2015, 29 days in July 2015 and each day that they were in the home in August 2015. Review of the clinical record and interview with the DOC on October 29, 2015, confirmed that the resident was not referred to the registered dietitian and was not reassessed when their care needs changed related to hydration. (156) (156)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 02, 2016

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_214146_0009, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall protect residents from abuse by anyone, including other residents, specifically resident #050.
The home shall develop a plan of care for resident #050 to ensure that the resident's safety considerations are consistently met and ensure that this individualized plan is complied with.
The home will ensure that all strategies identified to protect residents from abuse by resident #050, include but are not limited to:
A. annual training of all staff on the Prevention of Abuse and Neglect policy, which meets the legislative requirements, as required by the LTCHA and Regulation, including their responsibilities for reporting all witnessed, suspected or allegations of abuse from anyone
B. consistent monitoring of the resident
C. regular room checks for items which could potentially be used to harm others
D. immediately implement any other interventions identified in the future for resident #050 related to the safety of self and others.

Grounds / Motifs :

1. Non-complaince for LTCHA, 2007 s. 19(1) was served as a CO in June 2015.

The licensee failed to ensure that the resident was protected from abuse.

The licensee was served an order under inspection 2015-214146-0009, on June 24, 2015, for failure to comply with section 19 (1) of the LTCHA, 2007, duty to protect. This order was the subject of a Director's Review and as a result the order served on June 24, 2015, was substituted with a Director's Order as

identified below and dated July 30, 2015:
Pursuant to LTCHA, 2007, S.O. 2007, c.8, s. 19(1):
Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.
Order:
The licensee will protect residents from abuse by anyone, including other residents, specifically resident #001. The home will immediately create and implement strategies to protect residents from abuse by resident #001 including but not limited to annual training of staff as required by the LTCHA and Regulation, consistent monitoring of the resident, regular room checks for items which could potentially be used to harm others, the implementation of any other interventions identified for resident #001 and utilize outside resources to assist in the management of cognitively impaired residents with responsive behaviours. In addition the licensee is to review their Abuse and Neglect policy, dated March 18, 2014, against the legislated requirements in the LTCHA and the Regulation. They are to update the policy to ensure it meets the requirements and then ensure staff receive training on the newly updated policy. The order was to be complied with by September 30, 2015.

i. The licensee failed to comply with the order when they did not provide training to staff on the newly updated Abuse and Neglect policy by September 30, 2015. Interview with the Administrator confirmed that the home placed an emphasis on the completion of the abuse modules in their Surge learning program; however, that this program nor the specific modules was specific to the home's policy or the changes made to the policy. It was confirmed that staff were not provided training on the home's newly updated abuse policy as required in the order. (168)
ii. Resident #050, who was previously identified as resident #001 during inspection 2015-214146-0009, had a history of responsive behaviors, which included physical aggression towards co-residents. The responsive behaviours of the resident were previously inspected by the Ministry of Health and Long-Term Care due to an injury caused to a co-resident and a compliance order was served related to duty to protect. A review of the clinical record, since the time of the previous inspection, identified that in July 2015, the physician wrote an order to "continue present one-to-one and all measures to prevent the resident from harming self or other". Thirteen days later, the physician's order identified that the home was to continue with one-to-one for the resident.
Registered staff #108 confirmed that the resident was provided one-to-one

supervision by PSW's on the day and evening shifts; however, that there were occasions when they could not fill the shifts and at that those times staff were directed to complete every 15 minute checks of the resident, in an effort to ensure safety.
During the time frame of July 6, 2015 until August 10, 2015, the resident was not consistently provided one-to-one supervision as per their care needs, as ordered by the physician to prevent harm to self or others, on fifteen separate occasions as confirmed by registered staff #108.
On a specified shift where one-to-one was not provided as required, the resident demonstrated behaviours which were deemed to be a threat to self or others and additional resources, from an outside agency were called in immediately to assist in the management of the situation. The home did not ensure that identified measures, which were an assessed need for the resident, were consistently in place to protect others from abuse. (123) (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2016

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. 91. (1) A licensee shall not charge a resident for anything, except in accordance with the following:

1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided.
2. For preferred accommodation, a resident shall not be charged more than can be charged for basic accommodation in accordance with paragraph 1 unless the preferred accommodation was provided under an agreement, in which case the resident shall not be charged more than the amount provided for in the regulations for the accommodation provided.
3. For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount.
4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for. 2007, c. 8, s. 91 (1).

Order / Ordre :

The licensee shall ensure that:
A. they provide, at no charge to the resident/representative a range of incontinent products that, are based on individual assessed needs as outlined in the regulations, including a pull up style product, effective immediately.
B. they will not charge for, or allow residents/representatives to bring in, incontinent products unless the resident/representative has requested the specific brand, which is not offered by the home and/or the use of the identified product is not an assessed need for the resident
C. they conduct an audit of all residents, who have resided in the home in the years of 2015 and 2016 to determine if they had used or are using a pull up style continent product:
ii. when a pull up product was/is used the home will determine, when the product was provided by the home, if the resident/representative was charged for the product and if the product is/was an assessed need.
iii. when the product was provided on the request of the home, and paid for by the resident/representative, the licensee will reimburse all actual or estimated expenses incurred by the resident/representative in 2015 and 2016, for the full cost of the products used by June 1, 2016.

Grounds / Motifs :

1. Non-compliance for LTCHA, 2007 s. 91(1) was not previously served in the past 3 years.

The licensee charged a resident for incontinent products which the regulations provide were not to be charged for.

Ontario Regulation 79/10 section 245 paragraph 1 identified the following: "The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act: 1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from, i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and ii. the Minister under section 90 of the Act".

The licensee received funding from the local health integration network under section 19 of the Local Health System Integration Act, 2006, for goods and services funded by the local health integration network under their service accountability agreement for continence care supplies.

The Long Term Care Home (LTCH) Policy, LTCH Required Goods, Equipment, Supplies and Services, dated July 1, 2010, identified that:
"The licensee must provide the following goods, equipment, supplies and services to long-term care (LTC) home residents at no charge, other than the accommodation charge payable under the Long-Term Care Homes Act, 2007 (LTCHA), using the funding the licensee receives from the Local Health Integration Network under the Local Health System Integration Act, 2006 (LHSIA) or the Minister under the LTCHA or accommodation charges received under the LTCHA.
2.1 Required Goods, Equipment, Supplies and Equipment
2.1.2 Continence Management Supplies
Continence management supplies including, but not limited to:
a. A range of continence care products in accordance with section 51 of the Regulation under the LTCHA".

Section 51(2) of the Regulation under the LTCHA identified the following:
"51. (2) Every licensee of a long-term care home shall ensure that, (f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; and (h) residents are provided with a range of continence care products that, (i) are based on their individual assessed needs, (ii) properly fit the residents, (iii) promote resident comfort, ease of use, dignity and good skin integrity, (iv) promote continued independence wherever possible, and (v) are appropriate for the time of day, and for the individual resident's type of incontinence".
If a resident was assessed to require a pull up style incontinent product it shall be provided as part of the range of continence care products to be provided at no charge by the home.

The licensee charge a resident for continence care products that the regulations indicated was not to be charged for.

A. The plan of care for resident #017 identified that they were independent with set up assistance for toileting and used a pull up style incontinent product. A progress note dated October 1, 2015, noted that the PSW reported that the resident usually toileted independently and continued to use the pull up program. A review of the resident's Statement of Account dated August 31, 2015, included a charge of $44.84 for incontinent products. Discussion with registered staff #107 confirmed that the resident wore a pull up style incontinent product

which was ordered by the home; however, charged to the resident's family.

B. Family of resident #053 identified that until a recent injury in October 2015, the resident required little assistance with their activities of daily living, including toileting. The plan of care identified that the resident was toileted with limited assistance of one staff. A review of the resident's Statements of Accounts dated September 30, 2015, August 30, 2015 and July 31, 2015, each included a charge of $46.08 for incontinent products. Discussion with registered staff #107 confirmed that the resident wore a pull up style incontinent product which was ordered by the home; however, charged to the resident's family.

C. A review of resident #054 Statements of Accounts dated September 30, 2015, August 30, 2015 and July 31, 2015, each included a charge of $46.08 for incontinent products. Discussion with registered staff #107 confirmed that the resident wore a pull up style incontinent product which was ordered by the home; however, charged to the resident's family.

Interviews with the registered staff #107 and #108 confirmed that the home ordered and provided pull up style incontinent products for residents with the consent of their families; however, that they were billed for these products as the home did not supply them. (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2016

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 91. (1) A licensee shall not charge a resident for anything, except in accordance with the following:

1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided.
2. For preferred accommodation, a resident shall not be charged more than can be charged for basic accommodation in accordance with paragraph 1 unless the preferred accommodation was provided under an agreement, in which case the resident shall not be charged more than the amount provided for in the regulations for the accommodation provided.
3. For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount.
4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for. 2007, c. 8, s. 91 (1).

Order / Ordre :

The licensee shall create, implement and submit a plan to ensure that all current and former residents since July 1, 2010, (the date of implementation of the LTCHA, 2007) will be reimbursed for all costs for pull up style continence care products, while a resident in the home.

This plan shall include:
A. an audit of all current and former residents to determine if they were charged for a pull up style incontinent product and the reason for the use of the product
B. the total number of individuals charged for the pull up products and the amounts to be reimbursed
C. a schedule for reimbursement of these current and former residents/representatives for the full cost of the products used during their length of stay by December 31, 2016.

The home will submit the results of their initial audits by April 30, 2016, and their reimbursement plan for all current and former residents/representatives on a quarterly basis, to Lisa.Vink@ontario.ca, until December 30, 2016, at which time all costs incurred shall be reimbursed.

Grounds / Motifs :

1. Non-compliance for LTCHA, 2007 s. 91(1) was not previously served in the past 3 years.

The licensee charged a resident for incontinent products which the regulations provide were not to be charged for.

Ontario Regulation 79/10 section 245 paragraph 1 identified the following: "The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act: 1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from, i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and ii. the Minister under section 90 of the Act".

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2.1.2 Continence Management Supplies
Continence management supplies including, but not limited to:
a. A range of continence care products in accordance with section 51 of the Regulation under the LTCHA".

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If a resident was assessed to require a pull up style incontinent product it shall be provided as part of the range of continence care products to be provided at no charge by the home.

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C. A review of resident #054 Statements of Accounts dated September 30, 2015, August 30, 2015 and July 31, 2015, each included a charge of $46.08 for incontinent products. Discussion with registered staff #107 confirmed that the resident wore a pull up style incontinent product which was ordered by the home; however, charged to the resident's family.

Interviews with the registered staff #107 and #108 confirmed that the home ordered and provided pull up style incontinent products for residents with the consent of their families; however, that they were billed for these products as the home did not supply them. (168)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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 23rd day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA VINK

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