Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l’inspection	Log # / Registre no	Type of Inspection / Genre d’inspection
Feb 23, 2017	2017_573581_0002	000967-17	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

DIANNE BARSEVICH (581), CYNTHIA DITOMASSO (528)

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): January 13, 16, 18, 19, 20, 23, 24, 25, 26, 27 and 30, 2017.

During the course of this inspection the following inspections were conducted concurrently:
Complaint Inspections:
032441-16-related to staff to resident abuse and personal care
029669-16- related to continence care and bowel management

008534-16- related to plan of care
008753-16- related to staffing
009579-16- related to registered nurses and Administrator hours
000168-17- related to personal care-bathing
029755-16- related to staffing, registered nurses and dietary hours

CIS Inspections:
032846-15- related to falls prevention
009695-16- related to falls prevention
017312-16- related to responsive behaviours

Follow-Up Inspections:
CO #001 from RQI # 2015_188168_0031- related to plan of care being reviewed and revised when the residents' care needs changed related to restraint usage and nutrition and hydration needs
CO #002 from RQI #2015_188168_0031- related to prevention of abuse and neglect
CO #003 from RQI # 2015_188168_0031- related to the home charging residents for anything that the regulation provided for; specifically continence products
CO #004 - from RQI # 2015_188168_0031 – related to the home accepting payments from residents and families for continence products

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Programs Manager, Activity Aide, Maintenance Supervisor, Physiotherapist (PT), Occupational Therapist (OT), Food Service Manager (FSM), Dietary staff, Behavioural Supports Ontario (BSO) staff, Pharmacist, Ward Clerk, Housekeeping staff, families and residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
27 WN(s)
15 VPC(s)
7 CO(s)
1 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2015_188168_0031	581
LTCHA, 2007 S.O. 2007, c.8 s. 91. (1)	CO #003	2015_188168_0031	528
LTCHA, 2007 S.O. 2007, c.8 s. 91. (1)	CO #004	2015_188168_0031	528

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. 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 residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A. On an identified day in December, 2016, resident #080 reported that they did not want Personal Support Worker (PSW) #143 providing care to them anymore. Review of investigation notes indicated that the resident reported the following:
On an identified day in December, 2016, the resident activated the call bell from the bathroom. PSW #143 answered the bell and asked the resident what they needed. The resident asked for assistance with an item, to which the PSW replied that the resident or their nurse was able to do it. PSW #143 then requested that the resident perform a task but the resident refused and asked for more time. The resident then stated that PSW #143 pulled them and they hit a specified area of their body. Statements from Registered Practical Nurse (RPN) #144 revealed that they had observed PSW #143 use inappropriate statements to two separate residents and confirmed they had corrected them, explaining it was offensive more than once; however, the PSW continued to say the comments. Investigation notes confirmed that after interviews with PSW #143 allegations of abuse were substantiated.

Review of PSW #143's file revealed two undated statements from staff expressing concerns of neglect and mistreatment of residents and a third dated in 2016. Interview with the Administrator confirmed that management had not disciplined the staff member despite staff having ongoing concerns and their documented history. Interview with RPN #101 confirmed that staff had ongoing concerns about PSW #143 related to improper care of residents.

The home did not protect the resident's from abuse and neglect, including resident #080, when PSW #143 continued to provide care in the home despite ongoing concerns from staff.

B. A review of the Critical Incident Report sent by the home on an identified day in June 2016, indicated that on a specific day in June 2016, resident #046 had an altercation with resident #044 and resident #046 sustained an injury. The two residents were separated and the injury was treated. Review of the plan of care identified that resident #044 had a history of responsive behaviors towards co-residents. Review of the progress notes between April 2016 and January 2017, identified that the resident demonstrated responsive behaviours towards resident #046 on the following dates:
i. Two identified days in April 2016 and no injuries were documented; however, there were no follow-up notes related to monitoring for any injuries. On one of the identified days in April 2016, there was no documentation in the plan of care of the incident and therefore there was no further monitoring or assessment of resident #046 for any further

injuries.
ii. Three identified days in May 2016 and no injuries were documented; however, with one incident in May 2016, no further assessment of the injury was documented.
iii. Three identified days in June 2016, with two of the days resulting in an injury and after one of the identified days there was no further assessment of the injury or follow-up note documented. The second incident in June 2016, was not documented in their plan of care and therefore no follow-up note was documented related to further assessment of the resident or monitoring for any injuries.
iv. One identified day in August 2016, no injury was noted at the time of assessment.
v. Two identified days in October 2016, no injuries were noted at the time of the assessment; however, no follow-up notes were documented related to monitoring for any further injuries.
vi. Two identified days in November 2016, no injuries were noted at the time of the assessment; however, no further assessments and no follow-up notes were documented related to monitoring for any injuries.
vii. One identified day in December 2016, no injury was documented at the time of the assessment; however, no follow-up note was documented related to monitoring the resident for any injury.
viii. One identified day in January 2017 and no injury was documented as staff intervened.

Interview with PSW #132, stated that both residents had responsive behaviours and that the front line staff needed to implement interventions to respond to their responsive behaviours. Interview with registered staff #133 stated that resident #046 was a trigger for increased responsive behaviours and that Behaviour Supports Ontario (BSO) staff did assess resident #044 several times between an identified day in June and an identified day in July 2016, but their strategies and interventions were not implemented.

Interview with the Administrator and the DOC on January 27, 2017, confirmed that the home did not protect resident #046 from abuse. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.
DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: 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 where bed rails were used, the resident was assessed, his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Prevailing practices were identified in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), the decision to use, continue to use, or to discontinue the use of a bed rail would be made within the context of an individual resident assessment using an interdisciplinary team with input from the resident or the residents substitute decision maker (SDM). The guideline emphasizes the need to document clearly whether interventions were used and if they were appropriate or effective. Other questions to be considered would be the resident’s medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors, the status of the resident’s bed (whether passed or failed zones 1-4). Consideration of these factors

would more accurately guide the assessor in making a decision, with either the resident or by the resident's SDM about the necessity and safety of a bed rail. The final conclusion would then be documented on a form (electronically or on paper) as to why one or more bed rails were required, the type of rail, when the rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

A. On an identified day in January 2017, resident #014 was observed in bed with two bed rails in the raised position. A review of the plan of care did not include an assessment of the resident for the use of the two bed rails for repositioning. Interview with RN #121 stated the resident had two bed rails that they used for bed mobility and repositioning and confirmed an assessment of the bed rails was not completed. Interview with the DOC confirmed that no bed rail assessments have been completed in the home.

B. Observations made on an identified day in January 2017, revealed that resident #014, resident #052 and resident #058 had one portable bed rail on their bed, resident #054 and resident #056 had two portable bed rails on their bed. Review of the plan of care for all five residents identified that a bed rail assessment was not completed. Interview with the Administrator and DOC stated they were unaware the beds had portable bed rails, that the residents were not assessed for the portable bed rails and were not evaluated for entrapment risk to the residents. The Administrator stated that portable bed rails would not be allowed to be on any resident’s bed due to the high risk of entrapment and removed all the portable bed rails off the residents’ beds. [s. 15. (1) (a)]

2. The licensee failed to ensure that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A. On an identified day in January, 2017, resident #060 was observed in bed, with a specific surface on their bed frame and two three quarter bed rails were raised. Review of the written plan of care did not identify they were on a specific surface; however, revealed that two full bed rails were raised when in bed for safety. Review of the Facility Entrapment Inspection Sheet dated September 21, 2016, indicated that the resident was on a specific surface and the bed system failed zone one. Interview with the Maintenance Supervisor stated that entrapment zones were assessed but failed as the resident was lying on a specific surface.

B. Resident #062 was observed in their bed with a specific surface on their bed frame on an identified day in January 2017 and two three quarter bed rails were raised. Review of the written plan of care identified that no bed rail assessment was completed, they required two full bed rails raised when in bed and did not specify that they required a specific surface. Review of the Facility Entrapment Inspection Sheet dated September 21, 2016, revealed they had a specific surface and that the bed system failed zones one and four. During an interview with the Maintenance Supervisor they stated that entrapment zones were assessed but failed as the resident was lying on a specific surface.

Interview with Maintenance Supervisor who tested all the beds in the home for zones of entrapment stated that both of the specific surfaces failed zones of entrapment and confirmed that no bed accessories were in place on the bed to mitigate the risk of potential entrapment for both of these residents. They stated that all specific surfaces in

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 O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers and full body sponge baths and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A. In January 2017, anonymous concerns were sent to the Ministry of Health and Long Term Care (MOHLTC) identifying concerns that residents were missing baths due to the home working short staffed.

B. On an identified day in January 2017, the home worked short one PSW staff and interview with PSW #113 revealed that as a result, the resident's would not be receiving their scheduled bath, which was a consistent issue. The following resident's plans of care were reviewed on an identified day in January 2017 and identified scheduled baths were not consistently provided to the residents.
i. The plan of care for resident #017 identified that the resident was to receive a scheduled bath twice a week and required extensive assistance of one person. Review of Point of Care documentation for bathing identified that the resident only received one bath a week for two specific weeks in December 2016 and received one bath for one specific week in January 2017 and another week they did not receive any baths.
ii. The plan of care for resident #086 identified that the resident was to receive a scheduled bath twice a week, requiring care of two persons. Review of POC documentation revealed the resident only received one bath in a specific week in October, November and December, 2016 and in January 2017 only received one bath a week for two specific weeks and no baths were documented during another identified week.
iii. The plan of care for resident #087 identified that the resident was to receive a scheduled bath twice a week and required extensive assistance of one person. Review of POC documentation identified the resident only received one bath during an identified week in October, three specific weeks in November and December, 2016 and one identified week in January 2017 and no baths were documented during another specific week in January 2017.

Interview with RPN #100, PSW #124, PSW #123, PSW #113 and PSW #117 confirmed that the home regularly worked short staffed and therefore, were unable to provide residents with their scheduled bath. Furthermore, baths were not made up unless extra staff were called in to help, otherwise, PSW staff continued on with the bathing schedule when enough staff were on the floor and confirmed residents were not getting the minimum requirement for bathing.

C. On an identified day in January 2017, resident #014 complained they missed their scheduled bath day due to short staffing. Review of POC documents from December 2016 and January 2017, identified the resident only received one bath per week. Review of the staffing schedule confirmed that the home had worked short staffed on the resident's scheduled bathing days. Interview with PSW #123 confirmed that when the home worked short staffed the PSW scheduled to give baths was moved to the floor and scheduled baths were not provided. [s. 33. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the staffing plan:
(a) provided for a staffing mix that was consistent with residents' assessed care and safety needs;
(b) sets out the organization and scheduling of staff shifts;
(c) promoted continuity of care by minimizing the number of different staff members who provided nursing and personal support services to each resident;
(d) included a back-up plan for nursing and personal care staffing that addressed situations when staff would not come to work (including 24/7 RN coverage);
(e) was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A. From April 2016 to January 2017, the Ministry of Health and Long Term Care (MOHLTC) received four anonymous complaints related to staffing of nurses within the home, not meeting residents needs. The four complaints were inspected concurrently with this Resident Quality Inspection (RQI).

B. Review of the Resident Council minutes identified concerns related to staff working short as follows:
i. In July 2016, residents were concerned about long wait times for toileting over 30 minutes.
ii. In August 2016, residents complained about ongoing short staffing on weekends.
iii. In December 2016, residents voiced concern that due to staffing they were not receiving their scheduled baths.

The home had acknowledged the residents' concerns of the short staffing; however, the concerns remain ongoing.

C. In stage one, Resident Quality Inspection (RQI) interviews identified, one family and two residents, out of twelve that were interviewed, revealed that the home did not have enough staff to ensure that the residents got the care and assistance they needed without having to wait a long time.

D. On an identified day in January 2017, the provision of care was continuously observed on first floor:
i. Four PSW staff were assigned to resident care with one PSW staff member assigned to completing scheduled baths, a RPN administering medications and a Registered Nurse (RN) completing treatments and other tasks.
ii. From 0715 hours, PSW staff were observed providing continuous care to the residents without any breaks.
iii. Scheduled breakfast time was 0800 hours, as confirmed by the Food Service Manager (FSM) and initial documents provided by the home.
iv. At 0818 hours, resident #092 and resident #093 were seated in the small dining room and expressed frustration that the meal service had not been started and was “always late”. Seven residents were observed seated in the small dining room and meal service was not started until 0840 hours.
v. At 0825 hours, resident #015 was seated in the large dining room and expressed frustration with the home, reporting breakfast never started until 0900 hours, which was too long of a wait. Drink service began at 0847 hours and at 0900 hours breakfast cereal

service started.
vi. Interview with RPN #140 and PSW #142 confirmed breakfast did not start at 0800 hours on a routine basis and was even later when PSW staff worked short, which also happened on a regular basis. Interview with RPN #100 confirmed that resident #015 was affected regularly by short staffing, related to longer wait times for meals and assistance.
vii. In interviews with PSW #123, RPN #100 and dietary aide #116, staff were asked what time breakfast was supposed to start, to which all staff provided different times between 0815 and 0900 hours.

E. Interview with resident #015, PSW #113, PSW #123, PSW #117, PSW #142 and RPN #141 reported that nursing and PSW staff consistently worked short in the home. As a result, the PSWs scheduled to bathe residents were reassigned to assist with care on the floor, given a resident assignment and residents did not receive their scheduled bath. Review of the following residents' plans of care confirmed a minimum of two bathing days per week did not occur:
i. The plan of care for resident #017 identified that the resident was to receive a scheduled bath twice a week and required extensive assistance of one person. Review of Point of Care documentation for bathing identified that the resident only received one bath a week for two specific weeks in December 2016 and received one bath for one identified week in January 2017 and another week they did not receive any baths.
ii. The plan of care for resident #086 identified that the resident was to receive a scheduled bath twice a week, requiring care of two persons. Review of POC documentation revealed the resident only received one bath in a specific week in October, November and December, 2016 and in January 2017 only received one bath a week for two identified weeks and no baths were documented during another specific week and one of those days it was confirmed by the home they were working short staffed.
iii. The plan of care for resident #087 identified that the resident was to receive a scheduled bath twice a week and required extensive assistance of one person. Review of POC documentation indicated the resident only received one bath during an identified week in October, three specific weeks in November and December, 2016 and one specific week in January 2017 and no baths were documented during another identified week in January 2017.
iv. On an identified day in January 2017, resident #014 complained they missed their scheduled bath day due to short staffing. Review of POC documents from December 2016 and January 2017 identified that the resident only received one bath per week. Review of the staffing schedule confirmed that the home had worked short on the

resident's scheduled bathing days.

F. In 2016, resident #081 was admitted to the home. An admission note identified the resident required a specific dietary intervention to coincide with taking their medications. Due to staffing shortages, the resident was not provided with care as specified in their plan as follows:
i. In October 2016, an order documented by the Registered Dietitian (RD) requested that the resident receive a specific dietary intervention at a specified time. Interview with RPN #141 confirmed that it was difficult for staff to assist the resident with the specific dietary intervention at the new specified time, especially when the home often worked short PSW staff; therefore, the home decided to try and alter medication times slightly so that the resident could received the specific dietary intervention.
ii. On an identified day in October 2016, the resident refused to the dietary intervention at the new scheduled time and the dietary intervention was not offered or provided as required in their plan of care.
iii. Interview with RN #108 confirmed that on an identified day in October 2016, the dietary intervention was not offered and provided to the resident as per their schedule. Review of the plan of care included a physician consultation dated in November 2016, which stated that the resident had a specific diagnosis and was required to stay on the specific schedule, reiterating that the home was not to change the resident's schedule.
iv. The home did not provide the resident with the care set out in their plan related to their daily schedule of medications and food intake on a specified day in October 2016, when they tried to alter the resident's medication and dietary interventions to assist staff scheduling.

G. Review of the staffing schedule from April to December 2016, identified the home did not work with the scheduled staffing complement for PSWs and RPNs as follows:
i. In May 2016, the home worked short one PSW staff for 16 shifts, two PSWs for three shifts.
ii. In June 2016, the home worked short one PSW staff for seven shifts, one RPN for two eight hour shifts.
iii. In July 2016, the home worked short one PSW staff for 17 shifts, two PSWs for seven shifts, one RPN for two eight hour shifts and three 12 hours shifts.
iv. In August 2016, the home worked short one PSW staff for ten shifts, two PSWs for four shifts, three PSWs for one shift, one RPN for two eight hour shifts.
v. In September 2016, the home worked short one PSW staff for 12 shift, two PSWs for eight shifts, three PSWs for one shift, one RPN for five eight hour shifts and one 12 hour shift.

vi. In October 2016, the home worked short one PSW staff for 12 shifts, two PSWs for three shifts, one RPN for two eight hour shifts and one 12 hours shift.
vii. In December 2016, the home worked short one PSW staff for 24 shifts, two PSWs for nine shifts and three PSWs for two shifts.

H. Interview with RPN #100 confirmed that from May to August 2016, the staffing schedule was used to obtain the above numbers and the "call in forms" that the home used to track staff replacement were reviewed. Interview with the Ward Clerk and review of September, October and December 2016, staffing records, confirmed that sometimes the information identified on the "call in form" such as a sick call, were not always transcribed to the staffing schedule. Furthermore, "call in forms" were reviewed for the month of December 2016, only and the number of times staff worked short PSW staff was increased. The Ward Clerk also confirmed that review of staffing schedule versus "call in forms" would account for the lower numbers prior to December 2016.

I. Interview with the Ward Clerk and the Administrator confirmed that under previous management, staff were "self-scheduling" which included changing or giving away shifts without a formal process for tracking or approval. As a result the staffing complement had become inconsistent and did not provide for maximum continuity of care, as required in the Regulations. The home, as part of the staffing plan evaluation, had now created a process for exchanging and giving away shifts to promote continuity of resident care.

J. Interview with the DOC confirmed that the home did not have a backup plan to address situations when staff would not come to work and confirmed it was up to the registered staff to reassign tasks.

K. Interview with the DOC and Administrator confirmed that retaining staff had been a challenge at the home and ongoing efforts with hiring more staff continued.

L. The licensee failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times unless there was an allowable exception to this requirement.

The following were the exceptions outlined in subsection 45.(1) 2 of the Regulation:
For homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds;
i. In the case of a planned or extended leave of absence of an employee of the licensee who was a RN and a member of the regular nursing staff, a RN who worked at the home pursuant to a contract or agreement with the licensee and who was a member of the

regular nursing staff would be used,
ii. In the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation failed to ensure that the requirement under subsection 8 (3) of the Act was met, a RN who worked at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if,
A. The Director of Nursing and Personal Care or a RN who were both an employee of the licensee and a member of the regular nursing staff was available by telephone and
B. A RPN who was both an employee of the licensee and a member of the regular nursing staff was on duty and present in the home.
i. Review of the registered nursing staffing schedule from April to December 2016, which identified there was not a RN scheduled to work in the building, as follows:
a. In April 2016, the home worked without an RN in the building on two evening weekend shifts for eight hours.
b. In May 2016, the home worked without an RN In the building on two evening and one day shift, all weekend shifts for eight hours.
c. In July 2016, the home worked without an RN in the building one evening weekend shift for eight hours.
d. In August 2016, the home worked without an RN in the building six evening shifts for three hours each, all weekdays.
e. In October 2016, the home worked without an RN in the building on one night shift.
f. In November 2016, the home worked without an RN in the building two evening shifts for three hours each, all weekdays.
g. Interview with RPN #140 and RPN #100 who were regular staff confirmed that an RN had not always been in the building when they worked; however, was available by phone. The home did not ensure that on the days listed above, a RN was present in the building and did not meet the the exceptions outlined in subsection 45 (1) 2 of the Regulation.
h. Interview with the DOC and the Ward Clerk revealed that as of October 2016, the home had been utilizing agency RN to meet the exception requirements. [s. 31. (3)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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. (5) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care. 2007, c. 8, s. 6 (5).

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. (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 the written plan of care for each resident set out the planned care for the resident.

In May 2016, a progress note for resident #011 included a note from Restorative Care staff identifying that the resident had a specific device applied. Review of the written plan of care did not include any information related to the device. Interview with the Physiotherapist confirmed that the resident required the specific device to be applied by the physiotherapist or restorative staff daily and often required two staff for application of the device; however, the written plan of care did not set out the resident's care related to daily application of the device. [s. 6. (1) (a)]

2. The licensee failed to ensure that there was a written plan of care for each resident

that sets out, clear directions to staff and others who provided direct care to the resident.

A. Review of the current written plan of care for resident #015 identified under the eating focus they were on a specified diet; however, under nutritional status they had identified goals. Interview with dietary aide #145 stated the resident was on a different specified diet. Interview with the RD stated the resident was on a specific diet until an identified day in January 2017, was changed to the different identified diet and confirmed that the written plan of care did not set out clear directions to staff related to the resident's current diet plan.

B. The written plan of care for resident #017 was reviewed and identified they were frequently incontinent of bowel, occasionally incontinent of bladder and required a specific continence product during the day and evening shifts and a different continence product at night to manage their incontinence. Review of the continence logo in their room indicated they wore a specific continence product during the day and evening and a different continence product at night. Interview with PSW #146 stated they had provided primary care on evening shift for the past month, that the specific continence product did not fit and the resident required a different product. Interview with RN #122 stated that the logo in the resident's room was part of the plan of care and confirmed there was no clear direction to the front line staff as to which continence product the resident required and stated that the resident would need to be reassessed.

C. Review of resident #014's current written plan of care identified under Falls/Balance focus they were reassessed by the Physiotherapist on an identified day January 2016, for transfers and now required a specific lift for all transfers. Review of the transferring and toileting focus indicated they were transferred with supervision and set up help. Interview with PSW #103 stated the resident required the lift to transfer for all transfers. Interview with RN #121 confirmed that the resident's transfer had changed and that the written plan of care did not set out clear directions to direct care staff related to their transfers. [s. 6. (1) (c)]

3. The licensee failed to ensure that the resident, the SDM, if any, and the designate of the resident/SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

A. In December 2016, resident #083 was referred to the RD due to a diagnosis, as a result, the resident was assessed by the RD and they were changed to a specific dietary intervention. Review of the written order and progress notes, did not include

documentation that the substitute decision maker (SDM) was notified of the change. Interview with the RD and RN #121 confirmed they did not notify the family of the change in the resident's diet.

B. In December 2016, the home declared a respiratory outbreak and resident #083, as well as other residents in the home, required administration of a specific medication. Review of the plan of care did not include documentation that the SDM was notified of the new medication. Interview with RN #129 confirmed that the SDM was not notified when the resident was ordered and administered a new medication.

C. On February 3, 2016, resident #040 sustained an unwitnessed fall and sustained an injury. Review of the progress notes identified the SDM was not notified of the fall with injury. Interview with the DOC stated that the home's policy directed registered staff to notify the SDM of all falls, interventions and status of the resident and confirmed that registered staff should have called the SDM after the fall occurred. (581) [s. 6. (5)]

4. 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.

A. In August 2016, resident #081 was admitted to the home. An admission note identified the resident required specific dietary interventions to coincide with their medications at very specific times throughout the day. In October 2016, an order documented by the RD requested that the resident have a specific dietary intervention at a specific time. Interview with RPN #141 confirmed that it was difficult for staff to assist the resident at a specific time, especially when the home often worked short PSW staff; therefore, the home decided to try and alter the intervention times slightly so that the resident could received the dietary intervention at a new specific time.

On an identified day in October 2016, the resident refused the dietary intervention at the new specific time and therefore it was not offered or provided, as required in their plan of care. Interview with RN #108 confirmed that on an identified day in October 2016, the dietary intervention was not offered and provided to the resident as per the schedule. Review of the plan of care included a physician consultation dated in November 2016, which stated that the resident had a specific diagnosis and was required to stay on a specific schedule, reiterating that the home was not to change the resident's schedule. The home did not provide the resident with care set out in their plan related to their daily schedule of an intervention and food intake on an identified day in October 2016, when they tried to alter the interventions to assist staff scheduling.

B. On an identified day in January 2016, resident #081 was observed and was not provided with care as specified in their plan as follows:
i. Resident #081 was observed seated in their wheelchair in the bathroom and was trying to perform a specific task; however due to an identified diagnosis they were unable to perform the task independently. Inspector #528 asked the resident if they needed any assistance, to which the resident nodded positively. Approximately two minutes later, PSW #120 came into the resident's room and stated since the resident was able to perform the task with set up help they left the room. It was identified with PSW #120 that the resident was unable to perform the task independently. PSW #120 then asked the resident if they needed help, to which the resident nodded yes. Interview with PSW #120 confirmed that it was their first day with the resident and was not familiar with what type of assistance the resident required. Review of the plan of care identified that the resident required extensive assistance of one person with personal hygiene.
ii. The resident was then transported in their wheelchair from the bathroom to the bedside. PSW #120 ensured the resident did not need any further assistance and then left the room. The call bell was observed laying on the bed, not within the resident's reach. The written plan of care and kardex directed staff to ensure that the call bell was within reach at all times. Interview with PSW #120 confirmed that the call bell was not within the resident's reach, as required in their plan of care and placed it on their wheelchair.

C. In 2016, resident #081 was admitted to the home. An admission progress note stated the resident required assistance with feeding. Review of the written plan of care and kardex identified that the resident required extensive assistance with eating of one person due to a specific diagnosis. The kardex also identified that the resident required increased assistance with activities of daily living (ADL) in morning and at night when their symptoms due to a specific diagnosis increased. On a specified day in December 2016, the Occupational Therapist (OT) directed staff to assist the resident at meal times in a specific way.
i. On an identified day in January 2017, resident #081 reported to registered staff and their power of attorney (POA) that staff did not assist them with eating their meal. RPN #107, RN #108, PSW #111, PSW #110 and PSW #105 all confirmed they were working on the identified day in January 2017 and did not provide the resident assistance with eating, as they tried to encourage the resident to do as much as they were able to do on their own and they appeared to be managing and eating independently. PSW #105 stated that the resident would let the staff know if they needed assistance with meals. In an interview with PSW #106 on January 18, 2017, who was caring for the resident on the

identified day in January 2017, was unable to recall if they provided the resident with assistance. RN #108 confirmed that the resident continued to eat at a specified time but the resident was not being assisted with their meal. PSW #110 and PSW #111 confirmed they did not see any staff sitting with the resident while they were eating. PSW #105 reported call bells were going off and staff were assisting other residents with care needs.
ii. On an identified day in January 2017, at a specified time, the resident was not provided with extensive assistance with eating as required in their plan of care.

D. Review of the progress notes for resident #016 on an identified day in October 2016, indicated the resident received an identified diet texture and had an incident. Review of the plan of care identified they were to have a different identified diet texture for all meals and snacks as ordered by the RD. Interview with RN #108 who assessed the resident after the incident stated the resident was on a specific diet texture; however, received the wrong diet texture and confirmed they did not receive the diet texture as ordered on their plan of care. (581)

E. Resident #017 was observed wearing a specific continence product for continence care on two identified days in January 2017. Review of the written plan of care and the continence logo posted in their room identified they required a specific continence product on days and evening shifts for continence care. Interview with PSW #113 and PSW #146 stated they were to wear that specific continence product and were not sure why the resident was in a different continence product both days as the continence product was available. Interview with RN #122 stated the resident was assessed to use a specific continence product on day and evening shifts and confirmed that the resident was not provided with the continence product that was specified in the plan. [s. 6. (7)]

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.

On an identified day in January 2017, resident #014 was observed in bed with one three quarter bed rail padded on the right raised and one portable bed rail raised on the left side of the bed. Review of the plan of care identified that they had two half rails to aide in repositioning. Interview with RN #121 stated that resident did not have two half rails and confirmed that the plan of care was not reviewed and revised when their care needs changed related to bed rails. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the responsive behaviour program was being evaluated annually and updated in accordance with evidence-based practices or prevailing practices.

Interview with the Administrator and DOC confirmed that the home had not completed an evaluation of the Responsive Behaviour program in 2016. [s. 53. (3) (b)]

2. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, the behavioural trigger for the resident was identified.

Resident #044 had a history of responsive behaviours. Review of the progress notes for resident #046 from an identified day in April 2016, to an identified day in January 2017, identified that the resident demonstrated responsive behaviours towards resident #046 on the following dates:
i. Two times in April 2016 and no injuries were documented.
ii. Three times in May 2016 and no injuries were documented.
iii. Three times in June 2016, with an injury to the resident on two of the dates.
iv. One time in August 2016 and no injury was documented
v. Two times in October 2016 and no injuries were documented
vi. Two times in November 2016 and no injury was documented
vii. One time in December 2016 and no injury was documented
viii. January 5, 2017 and no injury was documented.

Review of the written plan of care identified under responsive behaviours their were specific interventions in place. Record review and interview with RPN #133 stated that resident #046 was a trigger in escalating resident #044's responsive behaviours and confirmed that this was not identified in the plan of care. [s. 53. (4) (a)]

3. The licensee failed to ensure that strategies were developed and implemented to respond to these behaviours.

A. Review of the MDS assessment in June, September and December 2016, for resident #044 identified they demonstrated responsive behaviours. Review of the plan of care identified they had an incident with resident #046, fifteen times between an identified day in April 2016 and an identified day in January 2017, with two of the incidents resulting in injuries to resident #046. Review of the Behavioural Supports Ontario (BSO) staff discharge summary on an identified day in July 2016, identified they had increased responsive behaviours due to co-residents' responsive behaviours. BSO staff documented the effective strategies and that these strategies were effective when utilized to manage resident #044's responsive behaviours. Review of the written plan of care revealed there were minimal interventions documented as strategies to manage

their responsive behaviours in particular the ones outlined by BSO staff. Interview with PSW #132 stated they were aware of the resident’s responsive behaviours, that resident #046 was a trigger for resident #044. They confirmed that there were no specific interventions documented in the Kardex and were not aware of the BSO strategies and intervention that were recommended. Interview with the Program Manager stated they were aware that BSO staff had assessed the resident and spoke briefly with them in regards to the interventions that the program department would be able to implement; however, confirmed the BSO interventions and strategies were not implemented by the program staff. Interview with RPN #133 confirmed that BSO staff developed strategies but they were not implemented to respond to resident #044’s responsive behaviours.

B. On an identified day in January 2017, resident #084 was observed in the hallway and asking staff specific questions. At a specific time, the resident asked RPN #140 a question and they answered and gave the resident specific directions. Approximately one minute later the resident passed by PSW #124 and asked a question related to the specific direction given by RPN #140 and the PSW replied, "I dont know" and continued walking away from the resident. Review of the plan of care identified that the resident was cognitively impaired and had specific interventions in place related to their questions and directed staff to implement the interventions when assisting the resident. Interview with RPN #120 confirmed that the resident required ongoing reassurance and directions. Interview with PSW #124 confirmed that they did not assist the resident on a specific task as required as a strategy to respond to the resident. (528) [s. 53. (4) (b)]

4. The licensee failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions were documented.

Review of the plan of care identified that Behavioural Supports Ontario (BSO) staff assessed the resident on an identified day in June 2016, related to a referral from the home due to an increase in responsive behaviours for resident #044. BSO staff implemented Dementia Observation System (DOS) charting on an identified day in June 2016 for five days; however it was not implemented by the home until BSO staff returned to the home and re-implemented it four days later. Review of the DOS charting record identified that it was not completed fully on three specific days in June 2016, was not completed at all on two other specific days in June 2016 and this was confirmed by RPN #126 who stated it was not completed as the home was short staffed. A review of the plan of care with RPN #133 stated that the BSO interventions were not documented in

the written plan of care and were therefore not implemented. Furthermore, staff tried an intervention to respond to the responsive behaviours between resident #044 and resident #046 but this was not always effective as resident #044 continued to display responsive behaviours toward resident #046 fifteen times between April 2016 and January 2017. RPN #133 confirmed that assessments, reassessments and interventions and the resident's responses to interventions were not consistently documented by the registered staff in the plan of care. [s. 53. (4) (c)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times unless there was an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45.(1) and 45.1 of the Regulation.

The following were the exceptions outlined in subsection 45.(1) 2 of the Regulation:
For homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds;
i. in the case of a planned or extended leave of absence of an employee of the licensee who was a RN and a member of the regular nursing staff, a RN who worked at the home pursuant to a contract or agreement with the licensee and who was a member of the regular nursing staff would be used,
ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation failed to ensure that the requirement under subsection 8 (3) of the Act

was met, a RN who worked at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party would be used if,
A. The Director of Nursing and Personal Care or a Registered Nurse who were both an employee of the licensee and a member of the regular nursing staff was available by telephone and
B. A registered practical nurse who was both an employee of the licensee and a member of the regular nursing staff was on duty and present in the home.

1. Review of the registered nursing staffing schedule from April to December 2016, which identified there was not a RN scheduled to work in the building, as follows:
i. In April 2016, the home worked without an RN in building on two evening weekend shifts for eight hours.
ii. In May 2016, the home worked without an RN in the building on two evenings and one day shift, all weekend shifts for eight hours.
iii. In July 2016, the home worked without an RN in the building one evening weekend shift for eight hours.
iv. In August 2016, the home worked without an RN in the building six evening shifts for three hours each, all weekdays.
v. In October 2016, the home worked without an RN in the building on one night shift.
vi. In November 2016, the home worked without an RN in the building two evening shifts for three hours each, all weekdays.

Interview with RPN #140 and RPN #100 who were regular staff confirmed that an RN had not always been in the building when they worked; however, was available by phone. The home did not ensure that on the days listed above, a RN was present in the building and did not meet the the exceptions outlined in subsection 45. (1) 2 of the Regulation.

Interview with the DOC and the Ward Clerk revealed that as of October 2016, the home had been utilizing agency RN to meet the exception requirements. [s. 8. (3)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #8: 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 the plan, policy, protocol, procedure, strategy or system was complied with.

A. The licensee was required under O. Reg. 79/10, s. 68 (2) (d) (e) to ensure that the Nutrition and Hydration Program included a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration and a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter.

The home's, "Nutrition and Hydration Program", dated April 2011, directed staff to monitor weight monthly.

a. The plan of care for resident #082 identified that the resident was a high nutritional risk with a specific goal weight. Review of the resident's weights revealed they had their weight taken in October and in November 2016 and no further weights were taken. Interview with RN #121 and the RD confirmed that although the resident was below their goal weight, monthly weights were not taken after November 2016.

b. The plan of care for resident #010 identified that the resident was a high nutritional risk with a specific goal weight. In October 2016, the resident's weight was recorded and their next monthly weight was not taken and recorded until January 2017. Interview with RN #121 and the RD confirmed that the resident was not weighed monthly between October 2016 and January 2017.

c. The home's "Nutrition and Hydration Program", DDM-I-50, dated April 2011, directed staff to record or report the resident's diet and fluid intake for meals and snacks.

The plan of care for resident #081 identified that the resident ate a specific amount of food in the day and required a specific diet for one meal. Upon review of the home's Dietary Reports, which included documentation of all food and fluid intake, it was noted that staff were not documenting the resident's food and fluid intake consistently.
i. In October 2016, dinner intake was not documented 20 times.
ii. In November 2016, dinner intake was not documented 15 times.
iii. In December 2016, dinner intake was not documented 19 times.
iv. In January 2016, dinner intake was not documented 13 out of 23 times.

Interview with the DOC and RD confirmed that the food and fluid intake records were not consistently completed for resident #081, as required in the home's policy.

d. The plan of care for resident #011 identified that the resident was a high nutritional risk and required total assistance with eating. Review of the Dietary Reports confirmed that the staff were not consistently documenting the residents intake of meals and snacks.
i. In November 2016, breakfast was not documented three times, morning snack was not documented 22 times, lunch was not documented nine times, afternoon snack was not documented 21 times, dinner was not documented two times and evening snack was not documented three times.
ii. In December 2016, breakfast was not documented four times, morning snack was not documented 25 times, lunch was not documented 10 times, afternoon snack was not documented 26 times and evening snack was not documented six times.

Interview with the DOC confirmed staff had not consistently documented resident #011's intake of food and fluid. Interview with the RD confirmed that the staff were inconsistent with completing food and fluid intake records making it difficult to complete a comprehensive assessment of the resident.

B. The licensee was required under O. Reg. 79/10, s. 136 (1) to ensure, as part of the medication management system, that a written policy was developed in the home that provided for the ongoing identification, destruction and disposal of, all expired drugs, all drugs with illegible labels and all drugs that were in containers that do not meet the requirements for marking containers specified under subsection 156(3) of the Drug and Pharmacies Regulation Act.

The home's policy, "11.6 Storage of Discontinued/Surplus Narcotic/Controlled Drugs",

directed the home that the storage area for narcotic and controlled drugs awaiting destruction would meet criteria, including but not limited to, the bin would be a one way bin (drugs can be added, but not removed). The home would also utilize a tracing tool to list the discontinued narcotics and controlled drugs which were stored in the designated storage area. The discontinued list for narcotic and controlled drugs for destruction would be retained for two years or in accordance with Provincial Legislation requirements.

On an identified day in January 2017, it was observed that the storage area for narcotic and controlled drugs awaiting destruction was in a filing cabinet in the DOC's office. The bin was not a one way bin and when unlocked, medications could of been removed. Furthermore, the home did not keep a tracing tool listing the contents of the drug bin, or any records related to drug destruction. The home thought the Pharmacist took the logs out of the home after drug destruction. Interview with the Pharmacist confirmed that the logs were kept in the home when controlled substances were destroyed and the most recent destruction was in December 2016. The home did not comply with their policy related to the storage of controlled substances.

C. The licensee was required under O. Reg. 79/10, s. 68 (2) (a) (b) to ensure that the Nutrition and Hydration Program included the development and implementation, in consultation with a RD who was a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration and included the identification of any risks related to nutrition care and dietary services and hydration.

The home's identified policy directed staff that all residents were to be monitored by the interdisciplinary care team for identified symptoms and the RD was to be informed it these symptoms were noted.

Review of the progress notes for resident #016 on an identified day in October 2016, identified that the resident received a specific dietary texture and had an incident. Interview with the RD stated they did not receive a referral after the incident. Interview with RN #108 stated they were present at the time of the incident, confirmed that a referral should have been sent to the RD and that the home's policy was not complied with. (581) [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 #9: 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 of a Resident", NDM-III-226, dated August 31, 2015, identified that, all staff, volunteers, family members were required to: safeguard the resident immediately, notify the charge nurse and the charge nurse would immediately notify the DOC and Administrator and initiate the internal reporting of an alleged, suspected, or witnessed abuse/neglect on a resident form. Notify the MOHLTC Director immediately according to protocols established for reporting of abuse and critical incidents.

A. Review of the progress notes on an identified day in June 2016, for resident #046 included documentation that resident #044 had an altercation with resident #046 and they sustained an injury. Review of the CIS identified that this incident was not submitted to MOHLTC Director until three days after the incident occurred. Interview with the Administrator confirmed that the home's submission of alleged abuse was three days late and they did not comply with their policy.

B. Review of the progress notes for resident #044 on an identified day in June 2016, included documentation of an altercation between resident #44 and resident #048 which resulted in resident #44 being injured. Interview with RN #108 who was working on the day of the incident stated they did not recall if they informed the DOC or Administrator at the time of the incident. They confirmed they received training on prevention of abuse at the home. Interview with the Administrator stated this incident was not investigated by prior management of the home, a CIS was not submitted to the MOHLTC Director and confirmed the expectation that this type of allegation would be reported and investigated as per the home's policy.

C. Review of the progress notes for resident #046 identified that on an identified day in June 2016, there was an altercation between resident #044 and resident #046 and resident #046 sustained an injury. Interview with RPN #100 who completed the assessment stated they did not remember if they notified the DOC related to the incident. Interview with the Administrator stated this incident was not investigated by prior management of the home, a CIS was not submitted to the MOHLTC Director and confirmed the expectation that this type of allegation would be reported and investigated as per the home's policy. [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 #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care for the resident who required the use of a restraint included the consent by the resident or if the resident was incapable, by the SDM.

In September 2016, as a result of increased falls, the physician ordered that resident #010 wore a device when up in their wheelchair for safety. Review of the plan of care did not include a consent for restraint until January 2017. Furthermore, the restraint assessment and consent was for another device. Interview with registered staff #100 confirmed that the resident required the device as a restraint to keep the resident from falling and the assessment and consent were four months later after the resident had already been wearing the device in January 2017 and listed the incorrect restraint. [s. 31. (2) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care for the resident who require the use of a restraint includes the consent by the resident or if the resident is incapable, by the SDM, to be implemented voluntarily.

WN #11: 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 when a resident had fallen, the resident was assessed and that where the condition or circumstances for the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Review of the home's policies identified that when a resident had fallen, registered staff were to assess the resident using the following clinically appropriate assessment instruments:

i. The home's policy, “Falls Prevention and Management Program", dated March 2012, indicated when a resident had fallen, the registered staff would complete the head to toe assessment.

ii. Initiate Head Injury Routine (HIR) for all unwitnessed falls and witnessed falls that had resulted in a possible head injury or if the resident was on anticoagulant therapy. Monitor and record vital signs, pupils and hand grips every 15 minutes for the first half hour, if vital signs were stable, monitor and record hourly for the next two hours and then every four hours for the remainder of the 24 hour period post fall.

iii. Complete the Fall Risk Assessment after a fall, quarterly (according to the Resident Assessment Instrument (RAI), Minimum Data Set (MDS) 2.0 schedule) and when a change in health status puts the resident at increased risk for falling such as: two falls in 72 hours, more than three falls in three months, more than five falls in six months, significant change in health status and falls resulting in serious injury.
iv. Complete a Post Screen for Resident/Environmental Factors form.
v. Make a referral to the Falls Prevention Committee for resident who had fallen frequently as indicated by: two falls in 72 hours, more than three falls in three months and more than five falls in six months.

A. Review of the progress notes for resident #040 identified they had four unwitnessed falls on an identified day in January, two identified days in February and one identified day in March 2016, with the fall on an identified day in February 2016, resulting in an injury. Review of the plan of care identified the following:
i. The post fall assessment/head to toe assessment was not completed after the fall in January, an identified day in February 2016 and was not fully completed post fall with injury after the second fall in February 2016.
ii. The HIR was not initiated post unwitnessed fall in January, on an identified day in February and March 2016, as required by the home’s policy.
iii. The post falls screen for resident /environmental factors was not completed after the fall in January 2016 and one of the falls on an identified day in February 2016.
iv. The falls risk assessment was not completed after the fall on an identified day in February 2016, which resulted in an injury and was also not completed quarterly. It was was completed on an identified day in January and July 2016 but was not completed after three falls in three months. The resident fell multiple times in three months between an identified day in January and an identified day in April 2016.
v. Interview with DOC confirmed that a referral to the Falls Prevention Committee for resident #040 who had fallen multiple times in three months was not completed as required by the home's policy.

Interview with DOC confirmed that resident #040 was not assessed using a clinically appropriate assessment tool that was designed for falls as outlined in the home’s Falls Prevention and Management Program and the Head Injury policy after they sustained four falls.

B. Resident #042 sustained three unwitnessed falls on an identified day in November 2015, January and February 2016, with the fall in November 2015, resulting in an injury. Review of the plan of care revealed the following:

i. The falls risk assessment was not completed after the fall in November 2015, when the resident sustained an injury. Review of the plan of care identified that the last assessment was completed on an identified day in August 2014.
ii. The HIR was not initiated post unwitnessed fall on an identified day in January and February 2016.

Interview with the DOC stated that the Fall Risk Assessment should have been completed after the fall in November 2015 and quarterly by the registered staff as resident #042 was high risk for falling and the HIR should have been completed post both unwitnessed falls in January and February 2016. The DOC confirmed that resident #042 was not assessed using a clinically appropriate assessment tool after they sustained three unwitnessed falls.

C. Resident #010 had a risk for falling related to specific diagnoses as evidenced by a history of falls. In December 2016, the resident had an unwitnessed fall and sustained an injury. Review of the plan of care did not include a completed post fall assessment form and post fall screen for environmental factors. Interview with registered staff #100 confirmed that the paper assessment forms were not included with the post fall documentation, as required in the home's policy. (528) [s. 49. (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 resident who has fallen, has been assessed and if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On an identified day in June 2016, according to the progress notes there was an altercation between resident #044 and resident #050 which resulted in resident #044 sustaining an injury. Review of the plan of care revealed a skin and wound assessment to the specified area was not completed nor was there any follow-up notes or assessments completed after the incident occurred. Interview with RN #108 stated that treatment was initiated and documented that registered staff were to monitor the injury. Review of the progress notes with RN #108 confirmed there was no follow-up notes or assessments after the initial note of injury and that that the resident did not receive a skin assessment using a clinically appropriate assessment instrument as required. [s. 50. (2) (b) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, to be implemented voluntarily.

WN #13: 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 in 2016, did not include written responses within 10 days for the following concerns or recommendations identified:
i. During the January 22, 2016, meeting concerns/recommendations were raised related to laundry going into the wrong closets and staff taking residents' personal hangers and never getting them back and these two issues were not responded to in writing.
ii. During the May 20, 2016, meeting a concern was raised related to when the windows would be cleaned and the written response from the Administrator was not received until June 16, 2016.
iii. During the July 22, 2016, meeting a concern was raised related to resident's often having to wait up to half an hour to go to the bathroom or to get off the toilet and the written response was not received until August 9, 2016.
iv. During the August 19, 2016, meeting a concern was raised about closing bathroom doors when their roommate was in the shared bathroom and the home was continually short staffed on week-ends. The written response was not received until September 14, 2016.
v. During the November 18, 2016, meeting a concern was raised related to the cold air in the atrium and they requested if they could have a plate warmer in the dining room. There was no written response to these two issues.
vi. During the December 30, 2016, meeting concerns were raised related to menu's not being written on the white boards and there was no written response to this concern.

Interview with the Program Manager confirmed that written responses to concerns or recommendations fro Resident Council were not consistently being completed in 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 is responded to in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the persons who have received training under subsection (2) received retraining in the areas mentioned in that subsection at times or at intervals provided for in the Regulations. According to subsection (2) of the Act and section 219 of Ontario Regulation 79/10, staff were to receive training in Infection Prevention and Control annually.

Review of the home's 2016, education records, did not include any documentation for annual training for staff related to Infection Prevention and Control (IPAC). Interview with the Administrator and DOC confirmed that IPAC education was not completed by staff in 2016. [s. 76. (4)]

2. The licensee failed to ensure that direct care staff were provided with training on how to minimize the restraining of residents and how to restrain residents in accordance with the requirements for restraining that were set out in the Act and Regulations.

Review of education records for 2016, related to minimizing of restraints indicated the home did not ensure annual education was provided to staff based on the the Act and Regulations. The home's records indicated that 63.6 percent of the RN staff, 30 percent of RPN staff and 60.7 percent of PSW staff did not completed the annual training on minimizing of restraints.

Interview with the DOC confirmed that Surge Leaning for restraints was not completed consistently by all staff in the home. [s. 76. (7) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the persons who has received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. According to subsection (2) of the Act and section 219 of Ontario Regulation 79/10, staff are to receive training in Infection Prevention and Control annually and that direct care staff are provided with training on how to minimize the restraining of residents and how to restrain residents in accordance with the requirements for restraining that are set out in the Act and Regulations, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 77. Food service workers, minimums

Specifically failed to comply with the following:

s. 77. (1) Every licensee of a long-term care home shall ensure that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2) for,
(a) the preparation of resident meals and snacks; O. Reg. 79/10, s. 77 (1).
(b) the distribution and service of resident meals; O. Reg. 79/10, s. 77 (1).
(c) the receiving, storing and managing of the inventory of resident food and food service supplies; and O. Reg. 79/10, s. 77 (1).
(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service. O. Reg. 79/10, s. 77 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was sufficient food service workers for the home to meet the minimum staffing hours as calculated below for:
(a) the preparation of resident meals and snacks,
(b) the distribution and service of resident meals,
(c) the receiving, storing and managing of the inventory of resident food and food service supplies, and
(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident

meal preparation, delivery and service.

The minimum staffing hours would be calculated as follows:
M = A × 7 × 0.45
Where,
"M" is the minimum number of staffing hours per week, and
"A" is,
a) if the occupancy of the home is 97 per cent or more, the licensed bed capacity in the home for the week, or
b) if the occupancy of the home is less than 97 per cent, the number of residents residing in the home for the week, including absent residents.

A. From August to December 2016, Nutrition Services Department staffing schedules and Dietary Department Manual Staffing Plan were reviewed and identified a shortage in dietary staffing. The home did not meet the minimum staffing hours as follows:
i. From September 11 to 17, 2016, the weekly average census was 88 residents. The minimum required food service worker hours were 286.65 hours; however, the home provided 272 hours, totaling 14.65 hours less than the requirement.
ii. From September 18 to 24, 2016, the weekly average census was 90 residents. The minimum required hours were 286.65 hours; however, the home provided 264 hours that week, totaling 22.65 hours less than the requirement.
iii. From October 2 to 8, 2016, the weekly average census was 86 residents. The minimum required food service worker hours were 270.9; however, the home provided 264 hours that week, totaling six hours less than the requirement.
iv. From November 19 to 26, 2016, the weekly average census was 85 residents. The minimum required food service worker hours were 267.75 hours; however, the home provided 256 hours that week, totaling 11.75 hours less than the requirement.
v. From December 4 to 10, 2016, the weekly average census was 87 residents. The minimum required food service worker hours were 274.05 hours; however, the home provided 264 hours, totaling 10 hours less than the requirement.
vi. From December 11 -17, 2016, the weekly average census was 90 residents. The minimum required food service worker hours were 286.65; however, the home provided 272 hours, totaling 14.65 hours less than the requirement.
vii. From December 18-24, 2016, the weekly average census was 88 residents. The minimum required food service worker hours were 286.65 hours; however, the home provided 272 hours, totaling 14.65 hours less than the requirement.
vii. From December 25 to 31, 2016, the weekly average census was 83 residents. The minimum required food service worker hours were 261.45 hours; however, the home

provided 256 hours, totaling 5.45 hours less than the requirement.

Interview with the Food Service Manager (FSM) confirmed that the home recently lost some staff and had placed job advertisements for new food service workers; however, had not hired anyone at the time of the interview. The FSM acknowledged there were challenges with staff hours and consistent shortages of staff in the home. [s. 77. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is sufficient food service workers for the home to meet the minimum staffing hours as calculated below for:
(a) the preparation of resident meals and snacks,
(b) the distribution and service of resident meals,
(c) the receiving, storing and managing of the inventory of resident food and food service supplies and
(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 78. Food service workers, training and qualificationsTraining and qualifications

Specifically failed to comply with the following:

78. (1) Every licensee of a long-term care home shall ensure that food service workers hired on or after July 1, 2010, other than cooks to whom section 76 applies,
(a) have successfully completed or are enrolled in a Food Service Worker program at a college established under the Ontario Colleges of Applied Arts and Technology Act, 2002 or a Food Service Worker program provided by a registered private career college and approved by the Superintendent of Private Career Colleges under the Private Career Colleges Act, 2005;
(b) have successfully completed an apprenticeship program in the trade of Cook, Institutional Cook or Assistant Cook under the Apprenticeship and Certification Act, 1998 or the Ontario College of Trades and Apprenticeship Act, 2009; or
(c) have entered into a registered training agreement in the trade of Cook, Institutional Cook or Assistant Cook under the Apprenticeship and Certification Act, 1998 or the Ontario College of Trades and Apprenticeship Act, 2009.

Findings/Faits saillants :

1. The licensee failed to ensure that all food service workers hired after July 1, 2010, other than cooks to whom section 76 applies,
(a) successfully completed or were enrolled in a Food Service Worker program at a college established under the Ontario Colleges of Applied Arts and Technology Act,2002 or a Food Service Worker program provided by a registered private career college and approved by the Superintendent of Private Career Colleges under the Private Career Colleges Act, 2005;
(b) successfully completed an apprenticeship program in the trade of Cook, Institutional Cook or Assistant Cook under the Apprenticeship and Certification Act, 1998 or the Ontario College of Trades and Apprenticeship Act, 2009; or
(c) entered into a registered training agreement in the trade of Cook, Institutional Cook or Assistant Cook under the Apprenticeship and Certification Act, 1998 or the Ontario College of Trades and Apprenticeship Act, 2009.

In October 2016, anonymous concerns were submitted to the MOHLTC identifying that non food service workers had been working in the kitchen due to dietary staff shortage. Interview with Dietary Aide #116 confirmed that they had observed housekeeping staff working in the kitchen. Interview with housekeeping staff #134 confirmed they had worked in the kitchen on occasion but did not have any additional training related to food service work. Interview with PSW #131 and dietary aide #135 also confirmed that PSW staff who worked evenings on an identified home area were serving dinner meals from the servery and did not have additional food service worker training. Interview with the FSM confirmed that housekeeping staff #134 had worked in the kitchen, although they did not have any food service worker training, in emergency situations. Furthermore, PSW staff were not to be serving meals from the servery and it was the expectation of the home that they would wait for the dietary aide to serve the meals. Not all staff completing food service workers job duties had the required training. [s. 78. (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 all food service workers hired after July 1, 2010, other than cooks to whom section 76 applies,
(a) successfully complete or are enrolled in a Food Service Worker program at a college established under the Ontario Colleges of Applied Arts and Technology Act, 2002 or a Food Service Worker program provided by a registered private career college and approved by the Superintendent of Private Career Colleges under the Private Career Colleges Act, 2005;
(b) successfully complete an apprenticeship program in the trade of Cook, Institutional Cook or Assistant Cook under the Apprenticeship and Certification Act, 1998 or the Ontario College of Trades and Apprenticeship Act, 2009; or
(c) entered into a registered training agreement in the trade of Cook, Institutional Cook or Assistant Cook under the Apprenticeship and Certification Act, 1998 or the Ontario College of Trades and Apprenticeship Act, 2009, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that: resulted in a physical injury or pain to the resident, or caused distress to the resident that would potentially be detrimental to the resident's health or well-being.

A Critical Incident System (CIS) was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified day in June 2016, that reported that there was an altercation between two residents and one resident sustained an injury. Review of the progress notes on an identified day in June 2016, identified that resident #046 had an altercation with resident #044 and resident #046 sustained an injury. Review of the plan of care did not identify that the substitute decision maker (SDM) was notified of their injury. Interview with the SDM on an identified day in January 2017, confirmed that the home did not notify them of the incident. Interview with RPN #133 stated that the registered staff were to notify the SDM when they became aware of an instance of alleged abuse and stated that the resident did sustain an injury when they was an altercation with another resident and confirmed that the SDM was not notified. [s. 97. (1)(a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's SDM and any other person specified by the resident are immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that: resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident' s health or well-being, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer’s instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident’s response. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the physical device was applied in accordance with the manufacturer's instructions (if any).

A. On an identified day in January 2017, resident #010 was observed seated in a wheelchair with a device which was not applied according to the manufacturers's instructions. Interview with RPN #100 confirmed that the resident required the device for safety. Interview with PSW #114 confirmed that the device was not applied, as per manufacturer's instructions.

B. On an identified day in January 2017, resident #011 was observed seated in their wheelchair with a device that was not applied according to manufacturer's instructions. Interview with PSW #114 confirmed that the device was not applied per manufacturer's instructions. Interview with RPN #100 confirmed that the resident wore the physical device daily when seated in their chair.

C. On an identified day in January 2017, resident #091 was observed seated in their wheelchair, tilted, wearing a device that was not applied according to manufacturer's instructions. Interview with PSW #124 confirmed that the device and not applied per manufacturer's instructions. Review of the plan of care and interview with RPN #140 confirmed that the resident required the physical device daily when seated in their wheelchair for safety. [s. 110. (1) 1.]

2. The licensee failed to ensure that the documentation included all assessments, reassessments and monitoring, including the resident's response.

A. The plan of care for resident #010 identified that in September 2016, the resident required a device when seated in their wheelchair, as a restraint, to prevent falls. The home documented ongoing restraint monitoring on the Restraint and Observation Form which documented every two hour interventions including releasing of the restraint, standing and/or repositioning, active/passive exercise, observations for skin integrity or respiration impairment, hourly checks for safety, comfort and proper positioning and registered staff review every eight hours. Review of the Restraint and Observation Form from September 2016, to January 2017, revealed incomplete documentation as follows:
i. In September 2016, PSW and registered staff did not document restraint monitoring from 0600 hours to 1400 hours, additionally from 1400 to 2200 hours on nine days, and no documentation of resident monitoring was noted after an identified day in September 2016.
ii. In October 2016, incomplete documentation related to restraint monitoring was noted on 22 days.
iii. In November 2016, incomplete documentation related to restraint monitoring was noted on 23 days.
iv. In December 2016, incomplete documentation related to restraint monitoring was noted on 17 days.
v. In January 2017, incomplete documentation related to restraint monitoring was noted on 14 out of 19 days.

Interview with RN #121 and RPN #100 confirmed that the restraint monitoring records for resident #010 were incomplete.

B. The plan of care for resident #011 identified that since 2012, the resident required a device when seated in their wheelchair, as a restraint for safety. The home documented ongoing restraint monitoring on the Restraint and Observation Form which documented every two hour interventions including releasing of the restraint, standing and/or

repositioning, active/passive exercise, observations for skin integrity or respiration impairment, hourly checks for safety, comfort and proper positioning and registered staff review every eight hours. Review of the Restraint and Observation Form from October 2016 to January 2017, revealed incomplete documentation as follows:
i. In October 2016, incomplete documentation related to restraint monitoring was noted on 17 days.
ii. In December 2016, incomplete documentation related to restraint monitoring was noted on 19 days.
iii. In January 2017, incomplete documentation related to restraint monitoring was noted on 13 out of 19 days.

Interview with RN #121 and RPN #100 confirmed that the restraint monitoring records for resident #011 were incomplete. [s. 110. (7) 6.]

3. The licensee failed to ensure that the documentation included every release of the device and repositioning.

A. The plan of care for resident #010 identified that in September 2016, the resident required a device when seated in their wheelchair, as a restraint, to prevent falls. The home documented the release and repositioning of restraint devices on the Restraint and Observation Form which documented every two hour interventions, hourly checks safety checks and registered staff review every eight hours. Review of the Restraint and Observation Form from September 2016, to January 2017, revealed incomplete documentation as follows:
i. In September 2016, incomplete documentation related to releasing the device and repositioning was noted 31 out of 31 days.
ii. In October 2016, incomplete documentation related to releasing the device and repositioning was noted on 22 days.
iii. In November 2016, incomplete documentation related to releasing the device and repositioning was noted on 23 days.
iv. In December 2016, incomplete documentation related to releasing the device and repositioning was noted on 17 days.
v. in January 2017, incomplete documentation related to releasing the device and repositioning was noted on 14 out of 19 days.

Interview with RN #121 and RPN #100 confirmed that, although the resident was being repositioned and the device released every two hours, the restraint documenting records for resident #010 were incomplete.

B. The plan of care for resident #011 identified the resident required a device when seated in their wheelchair, as a restraint, for safety. The home documented the release and repositioning of restraint devices on the Restraint and Observation Form which documented every two hour
interventions, hourly checks safety checks, and registered staff review every eight hours. Review of the Restraint and Observation Form from October 2016, to January 2017, revealed incomplete documentation as follows:
i. In October 2016, incomplete documentation related to releasing the device and repositioning was noted on 17 days.
ii. In December 2016, incomplete documentation related to releasing the device and repositioning was noted on 19 days.
iii. In January 2017, incomplete documentation related to releasing the device and repositioning was noted on 13 out of 19 days.

Interview with RN #121 and RPN #100 confirmed that, although the resident was being repositioned and the device released every two hours, the restraint documenting records for resident #011 were incomplete. (528) [s. 110. (7) 7.] (528)

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 physical device is applied in accordance with the manufacturer's instructions (if any), that the documentation included all assessments, reassessments and monitoring, including the resident's response and to ensure that the documentation includes every release of the device and repositioning, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure that an analysis of the restraining of residents by use of a physical device was undertaken on a monthly basis.

During the course of the inspection, monthly restraint analysis records were requested from October 2016, to January 2017; however, the home was unable to provide such records. Interview with the Administrator and DOC confirmed that the home did not analyze restraints in the home monthly and therefore, did not have a record. [s. 113. (a)]

2. The licensee failed to ensure that the licensee once in every calendar year conducted an evaluation to determine the effectiveness of the policy and identify what changes and improvements were required to minimize restraining and ensure that restraining was done in accordance with the Act and Regulation.

During the course of the inspection, the home was unable to provide an annual evaluation for Minimizing of Restraints for 2016. Interview with the DOC and Administrator confirmed an annual program evaluation was not included as part of the home's records for Minimizing of Restraints in 2016. [s. 113. (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 an analysis of the restraining of residents by use of a physical device is undertaken on a monthly basis and that the licensee once in every calendar year conducted an evaluation to determine the effectiveness of the policy and identify what changes and improvements are required to minimize restraining and ensure that restraining is done in accordance with the Act and Regulation, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. On an identified day in January 2017, the medication cart located outside the small dining room was noted to be unlocked and unattended. A specific medication was resting on top of the medication cart unlocked. The RPN was administering medications to a resident in the dining room and the medication cart was not in eye sight. Interview with RPN #126 confirmed that the medication cart should have been locked and secured when unattended. (528)

B. On an identified day in January 2017, an unlocked medication cart was observed to be sitting in the hallway on the first floor, outside of a residents' room. RPN #107 was in the resident's room administering medication. The RPN's back was to the medication cart and was unaware the Long Term Care (LTC) Homes Inspector was able to open and close the medication cart drawers. When RPN #107 returned to the cart, they confirmed that the cart was not locked and secured when unattended. (581) [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

s. 221. (3) The licensee shall ensure that the training required under paragraph 2 of subsection 76 (7) of the Act includes training in techniques and approaches related to responsive behaviours. O. Reg. 79/10, s. 221 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all direct care staff were provided training in falls prevention and management

Review of the home’s Surge Learning course completion provided by the home identified that front line staff completed the following training in 2016;
i. Registered nurses(RN) completed 54.5 percent of Falls Prevention Part 1, 2, 3 and 4.
ii. Registered Practical Nurses (RPN) completed 66.7 percent of Falls Prevention Part 1 and 58.3 percent of Falls Prevention Part 2, 3 and 4.
iii. Personal Support Workers (PSW) completed 34.8 percent of Falls Prevention Part 1, 2 and 3 and 33.3 percent of Falls Prevention Part 4.

Interview with the DOC confirmed that all direct care staff did not complete the training in Falls Prevention and Management in 2016. [s. 221. (1) 1.]

2. The licensee failed to ensure that training was provided related to continence care and bowel management to all staff who provide direct care to residents on an annual basis.

Interview with the DOC and Administrator stated that they were unable to provide how many direct care staff completed the annual training related to Continence Care and Bowel Management and confirmed that it was not completed by all direct care staff in 2016. [s. 221. (1) 3.]

3. The licensee failed to ensure that the training required under paragraph 2 of subsection 76(7) of the Act included training in techniques and approaches related to responsive behaviours.

Interview with the Administrator and the DOC stated they were unable to provide the number of front line staff that attended training in Responsive Behaviours in 2016 and confirmed that not all staff received the annual training. [s. 221. (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 all direct care staff are provided training in falls prevention and management, that training was provided related to continence care and bowel management to all staff who provide direct care to residents on an annual basis and to ensure that the training required under paragraph 2 of subsection 76(7) of the Act includes training in techniques and approaches related to responsive behaviours, to be implemented voluntarily.

WN #22: 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. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

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

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

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

During the course of the inspection, the home was unable to provide an annual evaluation of the home's Infection Prevention and Control Program (IPAC). Interview

with the Administrator and DOC confirmed that the 2016 annual evaluation of the IPAC program was not completed. [s. 229. (2) (d)]

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

On an identified day in January 2017, resident #048 was observed in the hallway in front of the nurses station at a specific time with an identified symptom. One hour later the resident was still in the hallway with the same symptom. Interview with the RPN #140 stated that the resident was displaying a symptom of an infection, was assessed, treatment was provided and they were provided with a specific personal care task and stated that they should have been taken to their room. Interview with RN #121 stated the resident was assessed, they had changes in their vital signs and should have been isolated in their room, not taken for a specific personal care task and not left in the hallway where other residents, staff and families were walking by. Interview with PSW #123 confirmed that they gave the resident the specific personal care task even though they were displaying symptoms of an infection. Interview with RN #129 who was the IPAC lead stated that any resident who was displaying symptoms of an infection should of been isolated, not left in the hallway for over one hour, not given a specific personal care task and confirmed that staff did not participate in the implementation of the IPAC program. [s. 229. (4)]

3. The licensee failed to ensure that staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices; and the symptoms were recorded and that action was taken as required.

The home's, "Infection Control Surveillance Policy", ICM-VII-010, last dated March 2009, directed staff that when a resident exhibited signs and symptoms of infection to monitor the resident vitals, intake and output and document in the nurses narrative notes every shift the presence or absence of symptoms, for 48 hours after symptoms had subsided, or 48 hours after the last dose of antibiotics.

In February 2016, resident #083 began displaying symptoms of an infection. Medications were ordered the following day for the infection, at which time the symptoms were documented as worsening. Review of the progress notes from an identified day in February 2016, for three days, did not include documentation on every shift, as required in the home's policy. After an identified day in February 2016, there was no

documentation as to when the medications were completed or if the resident's symptoms had subsided. On an identified day in March 2016, registered staff documented a deterioration of the resident's condition and the resident was transferred to the hospital the following day for treatment of a specific diagnosis. Interview with IPAC lead confirmed that staff did not complete the required monitoring of the resident's symptoms every shift as required in the home's policy. [s. 229. (5) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Infection Prevention and Control program is evaluated and updated at least annually in accordance with evidence-based practices and if there are none, in accordance with prevailing practices, that all staff participated in the implementation of the infection prevention and control program and to ensure that staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and if there are none, in accordance with prevailing practices; and the symptoms are recorded and that action is taken as required, to be implemented voluntarily.

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

A. During the initial tour of the home, it was identified that the large enclosed outdoor patio did not have a resident-staff communication and response system and was used by residents. Interview with the Administrator stated the outdoor patio was used by residents and confirmed there was no communication and response system.

B. During the course of the inspection, the library on the third floor of the home did not include a call bell. Interview with the Ward Clerk confirmed that the library was used by residents, who were sometimes escorted up to the library and were never left unattended. (528) [s. 17. (1) (e)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the program included an annual resident satisfaction evaluation of continence care products in consultation with residents, substitute decision-makers and direct care staff and took into account the evaluation when making purchasing decisions, including when vendor contracts were negotiated or renegotiated.

Interview with the Administrator and DOC confirmed that the home did not complete an annual resident satisfaction evaluation of continence care products in consultation with residents, SDM and direct care staff in 2016. [s. 51. (1) 5.]

2. The licensee failed to ensure that each resident received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

The home's policy, "Continence Care and Bowel Management", NDM-III-240, dated November 30, 2011, identified that registered nursing staff would 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.

Resident #017 was admitted to the home in 2015. Review of the plan of care identified that Bladder and Bowel Continence Assessment was started on admission but was not completed as confirmed by RPN #126. The resident was continent of both bowel and bladder on admission; however, according to the Minimum Data Set (MDS) assessment completed in July 2016, the resident had a deterioration in their urinary continence. Interview with RN #129 confirmed that a Bladder and Bowel Continence Assessment was not completed when there was a change in their condition that affected their bladder or bowel continence and that quarterly reassessments were also not completed using a clinically appropriate assessment instrument that was designed for incontinence. [s. 51. (2) (a)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the menu cycle was reviewed by the Residents' Council.

Review of the Resident Council meeting minutes in 2016, identified that the menu cycle was not reviewed during the council meetings and this was confirmed by the Program Manager. [s. 71. (1) (f)]

WN #26: 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:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

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).

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:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, communication of the seven-day and daily menus to residents.

On an identified day in January 2017, resident #015 read the daily menu before entering the dining room. Upon closer inspection, Inspector #528 identified that the daily menu did not reflect the current menu and in fact was from the previous day. Interview with PSW #113 confirmed that the daily menu that was posted was incorrect. Furthermore, no mealtimes were posted in any of the dining rooms of the home. Interview with PSW #123 identified that the home used to post meal times and was unsure of why it stopped. Interview with PSW #123 and dietary aide #116 who could not recall the time of breakfast service saying it was between 0800 and 0900 hours. [s. 73. (1) 1.]

2. 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 in 2016, identified that the meal and snack times were not reviewed during the council meetings. Interview with the Program Manager confirmed that the meal and snack times were not reviewed as part of the Residents' Council meetings. [s. 73. (1) 2.]

3. The licensee failed to ensure that the resident was provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

On an identified day in January 2017, resident #081 reported that they were not assisted with eating as required in their plan of care. Interview with PSW #111 identified that the previous day the resident was assessed by the OT related to increased weakness to a specified area. Review of the plan of care on an identified day in January 2017, did not include any recommendations from the OT related to specific devices. Interview with OT confirmed that the resident required specific devices when eating; however, the order was not written for the devices until seven days after their assessment. Interview with RN #108 confirmed that the OT assessed the resident on an identified day in January 2017 and recommendation were not communicated until seven days later; therefore, all the devices were not provided to the resident on an identified day in January 2017. [s. 73. (1) 9.]

WN #27: 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) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

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 #040 sustained an injury post fall and was transferred to the hospital on an identified day in February 2016. The resident returned to the home four days later post injury. The Director was not notified of the incident until 23 days later, according to the Critical Incident Report. Interview with the new Administrator of the home confirmed that the MOHLTC was notified late. [s. 107. (3) 4.]

Issued on this 24th day of February, 2017

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANNE BARSEVICH (581), CYNTHIA DITOMASSO (528)
Inspection No. / No de l'inspection :	2017_573581_0002
Log No. / Registre no:	000967-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 23, 2017
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 :	Susan Hastings

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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)

Linked to Existing Order / Lien vers ordre existant: 2015_188168_0031, CO #002;

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 home shall ensure that resident #046 and #081 are protected from physical abuse by completing the following:
A. Develop a plan of care for resident #046 to ensure that the resident's safety considerations, responsive behaviours are consistently met and ensure that this individual plan is complied with.
B. 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.
C. Immediately implement and document in the plan of care any interventions identified in the future for resident #044 related to the safety of others specifically resident #046.
D. The home must report the use of physical force by a resident that causes physical injury or pain to the Ministry Health and Long Term Care and ensure that the resident's substitute decision maker (SDM), if any, and any other person specified by the resident, are notified immediately.
E. Any staff who have had concerns raised to the home, related to allegation of staff to resident abuse or neglect, are monitored and ongoing monitoring is documented.

Grounds / Motifs :

1. This order is based upon three factors where there has been a finding of non-compliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the non-compliance is isolated (1), the severity of the non-compliance has actual harm/risk (3), two

residents were not protected from abuse and the history of non-compliance under LTCHA, 2007, section s. 19 is ongoing (4) with an order issued previously in June 2015 as a Directors order and the order was reissued again as an order in February 2016.

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A. On an identified day in December, 2016, resident #080 reported that they did not want Personal Support Worker (PSW) #143 providing care to them anymore. Review of investigation notes indicated that the resident reported the following: On an identified day in December, 2016, the resident activated the call bell from the bathroom. PSW #143 answered the bell and asked the resident what they needed. The resident asked for assistance with an item, to which the PSW replied that the resident or their nurse was able to do it. PSW #143 then requested that the resident perform a task but the resident refused and asked for more time. The resident then stated that PSW #143 pulled them and they hit a specified area of their body. Statements from Registered Practical Nurse (RPN) #144 revealed that they had observed PSW #143 use inappropriate statements to two separate residents and confirmed they had corrected them, explaining it was offensive more than once; however, the PSW continued to say the comments. Investigation notes confirmed that after interviews with PSW #143 allegations of abuse were substantiated.

Review of PSW #143's file revealed two undated statements from staff expressing concerns of neglect and mistreatment of residents and a third dated in 2016. Interview with the Administrator confirmed that management had not disciplined the staff member despite staff having ongoing concerns and their documented history. Interview with RPN #101 confirmed that staff had ongoing concerns about PSW #143 related to improper care of residents.

The home did not protect the resident's from abuse and neglect, including resident #080, when PSW #143 continued to provide care in the home despite ongoing concerns from staff.

B. A review of the Critical Incident Report sent by the home on an identified day in June 2016, indicated that on a specific day in June 2016, resident #046 had an altercation with resident #044 and resident #046 sustained an injury. The two residents were separated and the injury was treated. Review of the plan of

care identified that resident #044 had a history of responsive behaviors towards co-residents. Review of the progress notes between April 2016 to January 2017, identified that the resident demonstrated responsive behaviours towards resident #046 on the following dates:
i. Two identified days in April 2016 and no injuries were documented; however, there were no follow-up notes related to monitoring for any injuries. On one of the identified days in April 2016, there was no documentation in the plan of care of the incident and therefore there was no further monitoring or assessment of resident #046 for any further injuries.
ii. Three identified days in May 2016 and no injuries were documented; however, with one incident in May 2016, no further assessment of the injury was documented.
iii. Three identified days in June 2016, with two of the days resulting in an injury and after one of the identified days there was no further assessment of the injury or follow-up note documented. The second incident in June 2016, was not documented in their plan of care and therefore no follow-up note was documented related to further assessment of the resident or monitoring for any injuries.
iv. One identified day in August 2016, no injury was noted at the time of assessment.
v. Two identified days in October 2016, no injuries were noted at the time of the assessment; however, no follow-up notes were documented related to monitoring for any further injuries.
vi. Two identified days in November 2016, no injuries were noted at the time of the assessment; however, no further assessments and no follow-up notes were documented related to monitoring for any injuries.
vii. One identified day in December 2016, no injury was documented at the time of the assessment; however, no follow-up note was documented related to monitoring the resident for any injury.
viii. One identified day in January 2017 and no injury was documented as staff intervened.

Interview with PSW #132, stated that both residents had responsive behaviours and that the front line staff needed to implement interventions to respond to their responsive behaviours. Interview with registered staff #133 stated that resident #046 was a trigger for increased responsive behaviours and that Behaviour Supports Ontario (BSO) staff did assess resident #044 several times between an identified day in June and an identified day in July 2016, but their strategies and interventions were not implemented.

Interview with the Administrator and the DOC on January 27, 2017, confirmed that the home did not protect resident #046 from abuse.

(581)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 07, 2017

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(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).

Order / Ordre :

The licensee shall complete the following:
1. Re-evaluate all of the bed systems in the home in accordance with Health Canada Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006"and document the results. At a minimum, documentation shall include type of mattress and unique mattress identifier, bed rail type, bed frame serial number, date evaluated, name of evaluator, zones tested, issues identified and follow up action taken if necessary.

2. Develop an assessment tool related to bed rail use and bed safety assessments to include all relevant questions and guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006".

3. An interdisciplinary team shall assess all residents who use one or more bed rails using the bed safety assessment too and document the assessed results and recommendations for each resident.

4. Update the written plan of care for those residents who require bed rails which have been identified after re-assessing each resident using the bed safety assessment tool. Include in the written plan of care any necessary accessories that are required to mitigate any identified bed safety hazards.

Grounds / Motifs :

1. This order is based upon three factors where there has been a finding of noncompliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the non-compliance is widespread (3), where most of the residents in the home have not been assessed for bed safety in accordance with prevailing practices, the severity of the non-compliance has a potential to harm residents who use bed rails (2) and the history of non-compliance under s. 15(1) of Ontario Regulation 79/10 is ongoing (4) with a VPC issued in October 2015.

The licensee failed to ensure where bed rails were used, the resident was assessed, his or her bed system was evaluated in accordance with evidence-

based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Prevailing practices were identified in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), the decision to use, continue to use, or to discontinue the use of a bed rail would be made within the context of an individual resident assessment using an interdisciplinary team with input from the resident or the residents substitute decision maker (SDM). The guideline emphasizes the need to document clearly whether interventions were used and if they were appropriate or effective. Other questions to be considered would be the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors, the status of the resident's bed (whether passed or failed zones 1-4). Consideration of these factors would more accurately guide the assessor in making a decision, with either the resident or by the resident's SDM about the necessity and safety of a bed rail. The final conclusion would then be documented on a form (electronically or on paper) as to why one or more bed rails were required, the type of rail, when the rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

A. On an identified day in January 2017, resident #014 was observed in bed with two bed rails in the raised position. A review of the plan of care did not include an assessment of the resident for the use of the two bed rails for repositioning. Interview with RN #121 stated the resident had two bed rails that they used for bed mobility and repositioning and confirmed an assessment of the bed rails was not completed. Interview with the DOC confirmed that no bed rail assessments have been completed in the home.

B. Observations made on an identified day in January 2017, revealed that resident #014, resident #052 and resident #058 had one portable bed rail on their bed, resident #054 and resident #056 had two portable bed rails on their bed. Review of the plan of care for all five residents identified that a bed rail assessment was not completed. Interview with the Administrator and DOC stated they were unaware the beds had portable bed rails, that the residents were not assessed for the portable bed rails and were not evaluated for entrapment risk to the residents. The Administrator stated that portable bed rails

would not be allowed to be on any resident's bed due to the high risk of entrapment and removed all the portable bed rails off the residents' beds. [s. 15. (1) (a)]

2. The licensee failed to ensure that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A. On an identified day in January, 2017, resident #060 was observed in bed, with a specific surface on their bed frame and two three quarter bed rails were raised. Review of the written plan of care did not identify they were on a specific surface; however, revealed that two full bed rails were raised when in bed for safety. Review of the Facility Entrapment Inspection Sheet dated September 21, 2016, indicated that the resident was on a specific surface and the bed system failed zone one. Interview with the Maintenance Supervisor stated that entrapment zones were assessed but failed as the resident was lying on a specific surface.

B. Resident #062 was observed in their bed with a specific surface on their bed frame on an identified day in January 2017 and two three quarter bed rails were raised. Review of the written plan of care identified that no bed rail assessment was completed, they required two full bed rails raised when in bed and did not specify that they required a specific surface. Review of the Facility Entrapment Inspection Sheet dated September 21, 2016, revealed they had a specific surface and that the bed system failed zones one and four. During an interview with the Maintenance Supervisor they stated that entrapment zones were assessed but failed as the resident was lying on a specific surface.

Interview with Maintenance Supervisor who tested all the beds in the home for zones of entrapment stated that both of the specific surfaces failed zones of entrapment and confirmed that no bed accessories were in place on the bed to mitigate the risk of potential entrapment for both of these residents. They stated that all specific surfaces in the home failed zones of entrapment.

(581)

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

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee shall complete the following:
1. Ensure that all residents are bathed at a minimum of twice a week by a method of their choice.
2. Any resident who misses a scheduled bath or shower due to the home being short staffed, has the missed bath or shower documented and made up the same week.
3. Develop an auditing process to ensure residents are receiving minimum bathing requirements.

Grounds / Motifs :

1. This order is based upon three factors where there has been a finding of noncompliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the non-compliance is widespread (3), where there were multiple weeks in the home that residents missed a scheduled bath or shower due to the home being short staffed, the severity of the non-compliance has minimal risk (1) as the residents did receive one scheduled bath and the history of non-compliance under r. 33(1) of Ontario Regulation 79/10 is ongoing (4) with a VPC issued in August 2014.

1. The licensee failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers and full body sponge baths and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A. In January 2017, anonymous concerns were sent to the Ministry of Health

and Long Term Care (MOHLTC) identifying concerns that residents were missing baths due to the home working short staffed.

B. On an identified day in January 2017, the home worked short one PSW staff and interview with PSW #113 revealed that as a result, the resident's would not be receiving their scheduled bath, which was a consistent issue. The following resident's plans of care were reviewed on an identified day in January 2017 and identified scheduled baths were not consistently provided to the residents.
i. The plan of care for resident #017 identified that the resident was to receive a scheduled bath twice a week and required extensive assistance of one person. Review of Point of Care documentation for bathing identified that the resident only received one bath a week for two specific weeks in December 2016 and received one bath for one specific week in January 2017 and another week they did not receive any baths.
ii. The plan of care for resident #086 identified that the resident was to receive a scheduled bath twice a week, requiring care of two persons. Review of POC documentation revealed the resident only received one bath in a specific week in October, November and December, 2016 and in January 2017 only received one bath a week for two specific weeks and no baths were documented during another identified week.
iii. The plan of care for resident #087 identified that the resident was to receive a scheduled bath twice a week and required extensive assistance of one person. Review of POC documentation identified the resident only received one bath during an identified week in October, three specific weeks in November and December, 2016 and one identified week in January 2017 and no baths were documented during another specific week in January 2017.

Interview with RPN #100, PSW #124, PSW #123, PSW #113 and PSW #117 confirmed that the home regularly worked short staffed and therefore, were unable to provide residents with their scheduled bath. Furthermore, baths were not made up unless extra staff were called in to help, otherwise, PSW staff continued on with the bathing schedule when enough staff were on the floor and confirmed residents were not getting the minimum requirement for bathing.

C. On an identified day in January 2017, resident #014 complained they missed their scheduled bath day due to short staffing. Review of POC documents from December 2016 and January 2017, identified the resident only received one bath per week. Review of the staffing schedule confirmed that the home had worked short staffed on the resident's scheduled bathing days. Interview with

PSW #123 confirmed that when the home worked short staffed the PSW scheduled to give baths was moved to the floor and scheduled baths were not provided.

(528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2017

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The home shall create, submit and implement a plan to ensure that the staffing plan meets the residents' assessed care and safety needs, including but not limited to:
A. Create a back up plan for personal care staffing that addresses situations when staff cannot come to work.
B. Identify strategies for promoting continuity of care for residents.
C. Identify strategies to maximize recruitment and retention of staff.
D. Develop a process to ensure that the home documents when staff can not come to work and that the staffing schedule is updated to reflect any changes.
E. Ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement.

The plan shall be submitted to cynthia.ditomasso@ontario.ca. no later than end of business day on March 31, 2017.

Grounds / Motifs :

1. This order is based upon three factors where there has been a finding of noncompliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the non-compliance is widespread (3), where there were multiple days in the home that the staff works short staff and is affecting resident care, the severity of the non-compliance has a potential to harm residents if there is not enough staff to provide care (2) and the history of non-compliance under r. 31(3) of Ontario Regulation 79/10 is ongoing (4) with a VPC issued in June 2015.

The licensee failed to ensure that the staffing plan:
(a) provided for a staffing mix that was consistent with residents' assessed care and safety needs;
(b) sets out the organization and scheduling of staff shifts;
(c) promoted continuity of care by minimizing the number of different staff members who provided nursing and personal support services to each resident;
(d) included a back-up plan for nursing and personal care staffing that addressed situations when staff would not come to work (including 24/7 RN coverage);
(e) was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A. From April 2016 to January 2017, the Ministry of Health and Long Term Care (MOHLTC) received four anonymous complaints related to staffing of nurses within the home, not meeting residents needs. The four complaints were inspected concurrently with this Resident Quality Inspection (RQI).

B. Review of the Resident Council minutes identified concerns related to staff working short as follows:
i. In July 2016, residents were concerned about long wait times for toileting over 30 minutes.
ii. In August 2016, residents complained about ongoing short staffing on weekends.
iii. In December 2016, residents voiced concern that due to staffing they were not receiving their scheduled baths.

The home had acknowledged the residents' concerns of the short staffing; however, the concerns remain ongoing.

C. In stage one, Resident Quality Inspection (RQI) interviews identified, one

family and two residents, out of twelve that were interviewed, revealed that the home did not have enough staff to ensure that the residents got the care and assistance they needed without having to wait a long time.

D. On an identified day in January 2017, the provision of care was continuously observed on first floor:
i. Four PSW staff were assigned to resident care with one PSW staff member assigned to completing scheduled baths, a RPN administering medications and a Registered Nurse (RN) completing treatments and other tasks.
ii. From 0715 hours, PSW staff were observed providing continuous care to the residents without any breaks.
iii. Scheduled breakfast time was 0800 hours, as confirmed by the Food Service Manager (FSM) and initial documents provided by the home.
iv. At 0818 hours, resident #092 and resident #093 were seated in the small dining room and expressed frustration that the meal service had not been started and was "always late". Seven residents were observed seated in the small dining room and meal service was not started until 0840 hours.
v. At 0825 hours, resident #015 was seated in the large dining room and expressed frustration with the home, reporting breakfast never started until 0900 hours, which was too long of a wait. Drink service began at 0847 hours and at 0900 hours breakfast cereal service started.
vi. Interview with RPN #140 and PSW #142 confirmed breakfast did not start at 0800 hours on a routine basis and was even later when PSW staff worked short, which also happened on a regular basis. Interview with RPN #100 confirmed that resident #015 was affected regularly by short staffing, related to longer wait times for meals and assistance.
vii. In interviews with PSW #123, RPN #100 and dietary aide #116, staff were asked what time breakfast was supposed to start, to which all staff provided different times between 0815 and 0900 hours.

E. Interview with resident #015, PSW #113, PSW #123, PSW #117, PSW #142 and RPN #141 reported that nursing and PSW staff consistently worked short in the home. As a result, the PSWs scheduled to bathe residents were reassigned to assist with care on the floor, given a resident assignment and residents did not receive their scheduled bath. Review of the following residents' plans of care confirmed a minimum of two bathing days per week did not occur:
i. The plan of care for resident #017 identified that the resident was to receive a scheduled bath twice a week and required extensive assistance of one person. Review of Point of Care documentation for bathing identified that the resident

only received one bath a week for two specific weeks in December 2016 and received one bath for one identified week in January 2017 and another week they did not receive any baths.
ii. The plan of care for resident #086 identified that the resident was to receive a scheduled bath twice a week, requiring care of two persons. Review of POC documentation revealed the resident only received one bath in a specific week in October, November and December, 2016 and in January 2017 only received one bath a week for two identified weeks and no baths were documented during another specific week and one of those days it was confirmed by the home they were working short staffed.
iii. The plan of care for resident #087 identified that the resident was to receive a scheduled bath twice a week and required extensive assistance of one person. Review of POC documentation indicated the resident only received one bath during an identified week in October, three specific weeks in November and December, 2016 and one specific week in January 2017 and no baths were documented during another identified week in January 2017.
iv. On an identified day in January 2017, resident #014 complained they missed their scheduled bath day due to short staffing. Review of POC documents from December 2016 and January 2017 identified that the resident only received one bath per week. Review of the staffing schedule confirmed that the home had worked short on the resident's scheduled bathing days.

F. In 2016, resident #081 was admitted to the home. An admission note identified the resident required a specific dietary intervention to coincide with taking their medications. Due to staffing shortages, the resident was not provided with care as specified in their plan as follows:
i. In October 2016, an order documented by the Registered Dietitian (RD) requested that the resident receive a specific dietary intervention at a specified time. Interview with RPN #141 confirmed that it was difficult for staff to assist the resident with the specific dietary intervention at the new specified time, especially when the home often worked short PSW staff; therefore, the home decided to try and alter medication times slightly so that the resident could received the specific dietary intervention.
ii. On an identified day in October 2016, the resident refused to the dietary intervention at the new scheduled time and the dietary intervention was not offered or provided as required in their plan of care.
iii. Interview with RN #108 confirmed that on an identified day in October 2016, the dietary intervention was not offered and provided to the resident as per their schedule. Review of the plan of care included a physician consultation dated in

November 2016, which stated that the resident had a specific diagnosis and was required to stay on the specific schedule, reiterating that the home was not to change the resident's schedule.
iv. The home did not provide the resident with the care set out in their plan related to their daily schedule of medications and food intake on a specified day in October 2016, when they tried to alter the resident's medication and dietary interventions to assist staff scheduling.

G. Review of the staffing schedule from April to December 2016, identified the home did not work with the scheduled staffing complement for PSWs and RPNs as follows:
i. In May 2016, the home worked short one PSW staff for 16 shifts, two PSWs for three shifts.
ii. In June 2016, the home worked short one PSW staff for seven shifts, one RPN for two eight hour shifts.
iii. In July 2016, the home worked short one PSW staff for 17 shifts, two PSWs for seven shifts, one RPN for two eight hour shifts and three 12 hours shifts.
iv. In August 2016, the home worked short one PSW staff for ten shifts, two PSWs for four shifts, three PSWs for one shift, one RPN for two eight hour shifts.
v. In September 2016, the home worked short one PSW staff for 12 shift, two PSWs for eight shifts, three PSWs for one shift, one RPN for five eight hour shifts and one 12 hour shift.
vi. In October 2016, the home worked short one PSW staff for 12 shifts, two PSWs for three shifts, one RPN for two eight hour shifts and one 12 hours shift.
vii. In December 2016, the home worked short one PSW staff for 24 shifts, two PSWs for nine shifts and three PSWs for two shifts.

H. Interview with RPN #100 confirmed that from May to August 2016, the staffing schedule was used to obtain the above numbers and the “call in forms” that the home used to track staff replacement were reviewed. Interview with the Ward Clerk and review of September, October and December 2016, staffing records, confirmed that sometimes the information identified on the “call in form” such as a sick call, were not always transcribed to the staffing schedule. Furthermore, “call in forms” were reviewed for the month of December 2016, only and the number of times staff worked short PSW staff was increased. The Ward Clerk also confirmed that review of staffing schedule versus “call in forms” would account for the lower numbers prior to December 2016.

I. Interview with the Ward Clerk and the Administrator confirmed that under previous management, staff were “self-scheduling” which included changing or giving away shifts without a formal process for tracking or approval. As a result the staffing complement had become inconsistent and did not provide for maximum continuity of care, as required in the Regulations. The home, as part of the staffing plan evaluation, had now created a process for exchanging and giving away shifts to promote continuity of resident care.

J. Interview with the DOC confirmed that the home did not have a backup plan to address situations when staff would not come to work and confirmed it was up to the registered staff to reassign tasks.

K. Interview with the DOC and Administrator confirmed that retaining staff had been a challenge at the home and ongoing efforts with hiring more staff continued.

L. The licensee failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times unless there was an allowable exception to this requirement.

The following were the exceptions outlined in subsection 45.(1) 2 of the Regulation:
For homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds;
i. In the case of a planned or extended leave of absence of an employee of the licensee who was a RN and a member of the regular nursing staff, a RN who worked at the home pursuant to a contract or agreement with the licensee and who was a member of the regular nursing staff would be used,
ii. In the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation failed to ensure that the requirement under subsection 8 (3) of the Act was met, a RN who worked at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if,
A. The Director of Nursing and Personal Care or a RN who were both an employee of the licensee and a member of the regular nursing staff was available by telephone and
B. A RPN who was both an employee of the licensee and a member of the regular nursing staff was on duty and present in the home.

i. Review of the registered nursing staffing schedule from April to December 2016, which identified there was not a RN scheduled to work in the building, as follows:
a. In April 2016, the home worked without an RN in the building on two evening weekend shifts for eight hours.
b. In May 2016, the home worked without an RN In the building on two evening and one day shift, all weekend shifts for eight hours.
c. In July 2016, the home worked without an RN in the building one evening weekend shift for eight hours.
d. In August 2016, the home worked without an RN in the building six evening shifts for three hours each, all weekdays.
e. In October 2016, the home worked without an RN in the building on one night shift.
f. In November 2016, the home worked without an RN in the building two evening shifts for three hours each, all weekdays.
g. Interview with RPN #140 and RPN #100 who were regular staff confirmed that an RN had not always been in the building when they worked; however, was available by phone. The home did not ensure that on the days listed above, a RN was present in the building and did not meet the the exceptions outlined in subsection 45 (1) 2 of the Regulation.
h. Interview with the DOC and the Ward Clerk revealed that as of October 2016, the home had been utilizing agency RN to meet the exception requirements.

(528)

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

Order # / Ordre no : 005

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. (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).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care for all residents including residents #016, #017 and #081 is provided to the residents as specified in their plans; including but not limited to:
A. Ensuring the resident receives the required diet texture for all meals and snacks, the assessed continence product is used, the correct type of assistance is provided related to feeding, personal hygiene, call bells are within reach and established feeding and medication times are followed.
B. The home shall educate the staff about ensuring the care plan is reviewed according to their policies prior to the provision of care and that examples are provided of what harm can happen to residents when staff fail to provide the care accordingly.
C. The home shall establish an auditing process to ensure ongoing compliance.

Grounds / Motifs :

1. This order is based upon three factors where there has been a finding of noncompliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the non-compliance is isolated (1), the severity of the non-compliance has actual harm/risk (3) as one resident was not given their required dietary texture and choked and the history of non-compliance under LTCHA, 2007, section 6(7) is ongoing (4) with a VPC issued in October 2015.

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.

A. In August 2016, resident #081 was admitted to the home. An admission note identified the resident required specific dietary interventions to coincide with their

medications at very specific times throughout the day. In October 2016, an order documented by the RD requested that the resident have a specific dietary intervention at a specific time. Interview with RPN #141 confirmed that it was difficult for staff to assist the resident at a specific time, especially when the home often worked short PSW staff; therefore, the home decided to try and alter the intervention times slightly so that the resident could received the dietary intervention at a new specific time.

On an identified day in October 2016, the resident refused the dietary intervention at the new specific time and therefore it was not offered or provided, as required in their plan of care. Interview with RN #108 confirmed that on an identified day in October 2016, the dietary intervention was not offered and provided to the resident as per the schedule. Review of the plan of care included a physician consultation dated in November 2016, which stated that the resident had a specific diagnosis and was required to stay on a specific schedule, reiterating that the home was not to change the resident's schedule. The home did not provide the resident with care set out in their plan related to their daily schedule of an intervention and food intake on an identified day in October 2016, when they tried to alter the interventions to assist staff scheduling.

B. On an identified day in January 2016, resident #081 was observed and was not provided with care as specified in their plan as follows:
i. Resident #081 was observed seated in their wheelchair in the bathroom and was trying to perform a specific task; however due to an identified diagnosis they were unable to perform the task independently. Inspector #528 asked the resident if they needed any assistance, to which the resident nodded positively. Approximately two minutes later, PSW #120 came into the resident's room and stated since the resident was able to perform the task with set up help they left the room. It was identified with PSW #120 that the resident was unable to perform the task independently. PSW #120 then asked the resident if they needed help, to which the resident nodded yes. Interview with PSW #120 confirmed that it was their first day with the resident and was not familiar with what type of assistance the resident required. Review of the plan of care identified that the resident required extensive assistance of one person with personal hygiene.
ii. The resident was then transported in their wheelchair from the bathroom to the bedside. PSW #120 ensured the resident did not need any further assistance and then left the room. The call bell was observed laying on the bed,

not within the resident's reach. The written plan of care and kardex directed staff to ensure that the call bell was within reach at all times. Interview with PSW #120 confirmed that the call bell was not within the resident's reach, as required in their plan of care and placed it on their wheelchair.

C. In 2016, resident #081 was admitted to the home. An admission progress note stated the resident required assistance with feeding. Review of the written plan of care and kardex identified that the resident required extensive assistance with eating of one person due to a specific diagnosis. The kardex also identified that the resident required increased assistance with activities of daily living (ADL) in morning and at night when their symptoms due to a specific diagnosis increased. On a specified day in December 2016, the Occupational Therapist (OT) directed staff to assist the resident at meal times in a specific way.
i. On an identified day in January 2017, resident #081 reported to registered staff and their power of attorney (POA) that staff did not assist them with eating their meal. RPN #107, RN #108, PSW #111, PSW #110 and PSW #105 all confirmed they were working on the identified day in January 2017 and did not provide the resident assistance with eating, as they tried to encourage the resident to do as much as they were able to do on their own and they appeared to be managing and eating independently. PSW #105 stated that the resident would let the staff know if they needed assistance with meals. In an interview with PSW #106 on January 18, 2017, who was caring for the resident on the identified day in January 2017, was unable to recall if they provided the resident with assistance. RN #108 confirmed that the resident continued to eat at a specified time but the resident was not being assisted with their meal. PSW #110 and PSW #111 confirmed they did not see any staff sitting with the resident while they were eating. PSW #105 reported call bells were going off and staff were assisting other residents with care needs.
ii. On an identified day in January 2017, at a specified time, the resident was not provided with extensive assistance with eating as required in their plan of care.

D. Review of the progress notes for resident #016 on an identified day in October 2016, indicated the resident received an identified diet texture and had an incident. Review of the plan of care identified they were to have a different identified diet texture for all meals and snacks as ordered by the RD. Interview with RN #108 who assessed the resident after the incident stated the resident was on a specific diet texture; however, received the wrong diet texture and confirmed they did not receive the diet texture as ordered on their plan of care.

(581)

E. Resident #017 was observed wearing a specific continence product for continence care on two identified days in January 2017. Review of the written plan of care and the continence logo posted in their room identified they required a specific continence product on days and evening shifts for continence care. Interview with PSW #113 and PSW #146 stated they were to wear that specific continence product and were not sure why the resident was in a different continence product both days as the continence product was available. Interview with RN #122 stated the resident was assessed to use a specific continence product on day and evening shifts and confirmed that the resident was not provided with the continence product that was specified in the plan.

(581)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2017

Order # / Ordre no : 006 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:
A. Develop a plan of care for resident #044 that identifies the resident's responsive behaviors including but not limited to: behavioural triggers where possible and strategies to respond to the behaviours.
B. Ensure that strategies developed by the interdisciplinary team, including BSO reports are made available to all staff.
C. Ensure that all staff are implementing the strategies developed to minimize the risk of altercations and potentially harmful interaction between residents specifically resident #044 and #046.
D. When any resident demonstrates responsive behaviours, including resident #044 and #046, staff are documenting the actions taken to respond to the needs of the resident.
E. Consistent monitoring of the resident #044's responsive behaviours.
F. Procedures and interventions are developed and implemented to minimize the risk of altercations between resident #044 and resident #046.
G. Annual training of all staff on Responsive Behaviours which meets the legislative requirements.

Grounds / Motifs :

1. This order is based upon three factors where there has been a finding of noncompliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the non-

compliance is isolated (1), the severity of the non-compliance has actual harm/risk (3) as there were multiple altercations with injury between residents related to responsive behaviors and the history of non-compliance under r. 53(a)(b)(c) of Ontario Regulation 79/10 is ongoing (4) with a VPC issued in August 2014.

The licensee failed to ensure that, for each resident demonstrating responsive behaviours, the behavioural trigger for the resident was identified.

Resident #044 had a history of responsive behaviours. Review of the progress notes for resident #046 from an identified day in April 2016, to an identified day in January 2017, identified that the resident demonstrated responsive behaviours towards resident #046 on the following dates:
i. Two times in April 2016 and no injuries were documented.
ii. Three times in May 2016 and no injuries were documented.
iii. Three times in June 2016, with an injury to the resident on two of the dates.
iv. One time in August 2016 and no injury was documented
v. Two times in October 2016 and no injuries were documented
vi. Two times in November 2016 and no injury was documented
vii. One time in December 2016 and no injury was documented
viii. January 5, 2017 and no injury was documented.

Review of the written plan of care identified under responsive behaviours their were specific interventions in place. Record review and interview with RPN #133 stated that resident #046 was a trigger in escalating resident #044's responsive behaviours and confirmed that this was not identified in the plan of care.
(581)

2. The licensee failed to ensure that strategies were developed and implemented to respond to these behaviours.

A. Review of the MDS assessment in June, September and December 2016, for resident #044 identified they demonstrated responsive behaviours. Review of the plan of care identified they had an incident with resident #046, fifteen times between an identified day in April 2016 and an identified day in January 2017, with two of the incidents resulting in injuries to resident #046. Review of the Behavioural Supports Ontario (BSO) staff discharge summary on an identified day in July 2016, identified they had increased responsive behaviours

due to co-residents' responsive behaviours. BSO staff documented the effective strategies and that these strategies were effective when utilized to manage resident #044's responsive behaviours. Review of the written plan of care revealed there were minimal interventions documented as strategies to manage their responsive behaviours in particular the ones outlined by BSO staff. Interview with PSW #132 stated they were aware of the resident's responsive behaviours, that resident #046 was a trigger for resident #044. They confirmed that there were no specific interventions documented in the Kardex and were not aware of the BSO strategies and intervention that were recommended. Interview with the Program Manager stated they were aware that BSO staff had assessed the resident and spoke briefly with them in regards to the interventions that the program department would be able to implement; however, confirmed the BSO interventions and strategies were not implemented by the program staff. Interview with RPN #133 confirmed that BSO staff developed strategies but they were not implemented to respond to resident #044's responsive behaviours.

B. On an identified day in January 2017, resident #084 was observed in the hallway and asking staff specific questions. At a specific time, the resident asked RPN #140 a question and they answered and gave the resident specific directions. Approximately one minute later the resident passed by PSW #124 and asked a question related to the specific direction given by RPN #140 and the PSW replied, "I dont know" and continued walking away from the resident. Review of the plan of care identified that the resident was cognitively impaired and had specific interventions in place related to their questions and directed staff to implement the interventions when assisting the resident. Interview with RPN #120 confirmed that the resident required ongoing reassurance and directions. Interview with PSW #124 confirmed that they did not assist the resident on a specific task as required as a strategy to respond to the resident. (528) (581)

3. The licensee failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Review of the plan of care identified that Behavioural Supports Ontario (BSO) staff assessed the resident on an identified day in June 2016, related to a referral from the home due to an increase in responsive behaviours for resident

#044. BSO staff implemented Dementia Observation System (DOS) charting on an identified day in June 2016 for five days; however it was not implemented by the home until BSO staff returned to the home and re-implemented it four days later. Review of the DOS charting record identified that it was not completed fully on three specific days in June 2016, was not completed at all on two other specific days in June 2016 and this was confirmed by RPN #126 who stated it was not completed as the home was short staffed. A review of the plan of care with RPN #133 stated that the BSO interventions were not documented in the written plan of care and were therefore not implemented. Furthermore, staff tried an intervention to respond to the responsive behaviours between resident #044 and resident #046 but this was not always effective as resident #044 continued to display responsive behaviours toward resident #046 fifteen times between April 2016 and January 2017. RPN #133 confirmed that assessments, reassessments and interventions and the resident's responses to interventions were not consistently documented by the registered staff in the plan of care.

(581)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 07, 2017

Order # / Ordre no : 007 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall:
A. Ensure that a Registered Nurse (RN) who is an employee of the home is scheduled to work in the home and on duty and present at all times unless the home meets the exception outlined in the Regulations, subsection 45 (1) 2.

Grounds / Motifs :

1. This order is based upon three factors where there has been a finding of non-compliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the non-compliance is patterned (2), a RN was not in the building at all times, the severity of the non-compliance is minimal harm or potential for actual harm (2), as there was potenitial risk related to the RN not working in the home on all three shifts consistently and the history of non-compliance under LTCHA, 2007, section s. 8 (3) is ongoing (2) with previous non-compliance unrelated.

The licensee failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times unless there was an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45.(1) and 45.1 of the Regulation.

The following were the exceptions outlined in subsection 45.(1) 2 of the Regulation:
For homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds;

i. in the case of a planned or extended leave of absence of an employee of the licensee who was a RN and a member of the regular nursing staff, a RN who worked at the home pursuant to a contract or agreement with the licensee and who was a member of the regular nursing staff would be used,
ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation failed to ensure that the requirement under subsection 8 (3) of the Act was met, a RN who worked at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party would be used if,
A. The Director of Nursing and Personal Care or a Registered Nurse who were both an employee of the licensee and a member of the regular nursing staff was available by telephone and
B. A registered practical nurse who was both an employee of the licensee and a member of the regular nursing staff was on duty and present in the home.

1. Review of the registered nursing staffing schedule from April to December 2016, which identified there was not a RN scheduled to work in the building, as follows:
i. In April 2016, the home worked without an RN in building on two evening weekend shifts for eight hours.
ii. In May 2016, the home worked without an RN in the building on two evenings and one day shift, all weekend shifts for eight hours.
iii. In July 2016, the home worked without an RN in the building one evening weekend shift for eight hours.
iv. In August 2016, the home worked without an RN in the building six evening shifts for three hours each, all weekdays.
v. In October 2016, the home worked without an RN in the building on one night shift.
vi. In November 2016, the home worked without an RN in the building two evening shifts for three hours each, all weekdays.

Interview with RPN #140 and RPN #100 who were regular staff confirmed that an RN had not always been in the building when they worked; however, was available by phone. The home did not ensure that on the days listed above, a RN was present in the building and did not meet the the exceptions outlined in subsection 45. (1) 2 of the Regulation.

Interview with the DOC and the Ward Clerk revealed that as of October 2016, the home had been utilizing agency RN to meet the exception requirements.

(528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 23rd day of February, 2017

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Dianne Barsevich

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