Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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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
Dec 2, 2015	2015_248214_0024	H-003451-15	Resident Quality Inspection

Licensee/Titulaire de permis

955464 ONTARIO LIMITED
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

CRESCENT PARK LODGE
4 Hagey Avenue Fort Erie ON L2A 5M5

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

CATHY FEDIASH (214), KELLY HAYES (583), ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 22, 23, 26, 27, 28, 29, 30, November 3, 4, 5, 2015.

Please note: The following inspections were conducted simultaneously with this RQI: Critical Incident System Inspection's: 002465-14; 002468-14; 004202-14; 002386-15; 009203-15; Complaint Inspection: 027418-15

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian (RD), Food Service Manager, Registered staff, Personal Support Workers (PSW), resident's and families. During the course of this inspection, the inspector's toured the home; reviewed resident health records; reviewed meeting minutes and internal investigation notes; reviewed policies and procedures; observed resident's in dining and care areas.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

7 WN(s)
5 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's plan of care was based on an assessment of the resident and the resident's needs and preferences.

A) Resident #010 was frequently incontinent of urine and continent of their bowels in May 2015. The resident then became frequently incontinent of both bladder and bowel in August 2015, due to a decline in their condition. A review of the resident's plan of care that staff refer to for direction in providing care to residents, had a focus for urinary incontinence; however; an assessment completed on an identified date in 2015 indicated that the resident was also incontinent of their bowels. There was no plan of care to

manage the resident's bowel incontinence based on this assessment.

It was confirmed during an interview with the RAI Coordinator on an identified date in 2015, that the resident's plan of care was not based on an assessment of the resident and the resident's needs and preferences.

B) Resident #005 had an unwitnessed fall on an identified date in 2015, and another unwitnessed fall on a later identified date in 2015. Post fall assessment's had been completed after each of these falls and had identified the resident as a high risk for falls. Fall prevention interventions were identified in these assessment's and had been implemented.

A review of the resident's plan of care indicated that post falls assessment's and quarterly falls assessment's had been completed; however; a fall's plan of care including a falls focus, goals and interventions had not been developed.

It was confirmed during an interview with the DOC that resident #005's plan of care was not based on an assessment of the resident's needs and preferences. [s. 6. (2)]

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

A) A review of resident #009's Minimum Data Set (MDS) coding for section H.-Continence in the last 14 days and completed on an identified date in 2015, indicated that the resident was coded as being occasionally incontinent of their bowels. A review of the Bowel and Bladder Assessment that was completed for this resident the day after, instructed the assessor under the first section to place a check mark for bladder and bowel only if incontinent. The section related to bowel incontinence was blank.

An interview with the RAI Coordinator confirmed that staff had not collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent and complemented each other.

B) Resident #003 was continent of their bowel on an identified date in 2014, and then became occasionally incontinent on an identified date in 2015, due to a decline in their condition. A review of the Bowel and Bladder assessment conducted on an identified

date in 2015, indicated that the resident was occasionally incontinent of bowel; however; the MDS that was coded on that same day indicated that the resident was continent of their bowel.

An interview with the RAI Coordinator on an identified date in 2015, confirmed that their assessments were not integrated, consistent with and complemented each other. (508) [s. 6. (4) (a)]

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

A) On an identified date in 2015, resident #201 fell out of their wheelchair attempting to self transfer to the toilet. The resident was transferred to hospital where it had been identified that the resident had sustained an identified injury. A review of the resident's clinical record indicated that the resident had been identified as a high risk for falls and specified fall prevention equipment had been implemented to minimize the risk of falls.

A review of the post fall assessment completed after this fall indicated that the resident's specified fall prevention equipment was on the resident's wheelchair at the time of the fall but it had not been turned on.

It was confirmed by documentation and during an interview with the DOC that the care set out in the plan of care had not been provided to the resident as specified in the plan.

PLEASE NOTE: This non-compliance was identified during a Critical Incident inspection, log #002386-15 conducted concurrently during the Resident Quality Inspection.

B) Resident #005 was identified as a high risk for falls on an identified date in 2015, and had sustained two falls on identified dates in 2015. A review of the resident's clinical record indicated that specified fall prevention equipment had been implemented when they were identified as a high risk for falls in 2015, to minimize the risk of falls.

On an identified date in 2015, the resident, was observed by the Long Term Care Homes (LTC) Inspector, sleeping in bed without the specified fall prevention equipment in place. A registered staff member was notified and had indicated that the specified fall prevention equipment had been on the resident's bed prior to this date, however, the specified fall prevention equipment was not in the resident's room and could not be located.

The staff member that manages the inventory and tracking of this specified fall prevention equipment was notified and indicated that they was not aware that it had been removed.

It was confirmed during an interview with the RAI Coordinator that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

4. 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 change or care set out in the plan was no longer necessary.

A) A review of resident #009's MDS coding for section H.-Continence in the last 14 days and dated on an identified in 2015, indicated that the resident was coded as being incontinent of their bladder. A review of the resident's MDS coding for section B.-Cognitive Patterns and dated the same date, indicated that the resident exhibited short term and long term memory problems; was moderately impaired for daily decision making and that their mental function varied over the course of the day. A review of the resident's written plan of care indicated under urinary incontinence with a identified date in 2014, that staff would teach the resident the importance of emptying their bladder completely.

An interview with registered staff confirmed that due to cognitive decline, the resident was no longer able to be taught to empty their bladder completely and that the plan of care had not been reviewed and revised when the residents care needs changed.

B) A review of the MDS coding for resident #003 completed on an identified date in 2014, indicated that the resident was continent of bowel. The MDS coded on an identified date in 2015, indicated that the resident had deteriorated and was occasionally incontinent of bowel. A review of the resident's plan of care that staff refer to for direction in providing resident care, indicated that the plan had not been updated when the resident's continence had deteriorated on an identified date in 2015.

It was confirmed during an interview with the RAI Coordinator on an identified date in 2015, that the plan of care for resident #003 had not been reviewed and revised when the resident's care needs changed. (508) [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's plan of care is based on an assessment of the resident and the resident's needs and preferences; to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other and to 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 the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed at least weekly by a member of the registered nursing staff, when clinically indicated.

A review of the skin and wound assessment's for resident #010 indicated that the resident had a new alteration in skin integrity to an identified area in 2015. Ten days later the skin and wound assessment completed identified this area had a stage II ulcer. A review of an identified period of four months in 2015, indicated that the wound had been assessed as a stage II and on four occasions the wound had not been assessed at least weekly.

On an identified date in 2015, the wound had been assessed as a stage II; however; the wound was not reassessed until approximately 47 days later, which indicated that the wound was unstageable.

It was confirmed during an interview with the RAI Coordinator on an identified date in 2015, that the resident who exhibited altered skin integrity, including pressure ulcers was not assessed at least weekly by a member of the registered nursing staff, when clinically indicated. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensue that the resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed at least weekly by a member of the registered nursing staff, when clinically indicated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with a change of 5 per cent of body weight, or more, over one month were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

A) A review of resident #009's plan of care identified they were assessed as being a high nutrition risk. The documented weights showed resident #009 had a weight loss of 12.3 per cent with a decrease of 7.7 kilograms within nineteen days. A review of the progress notes for an identified period of 25 days in 2015, showed there was no documented nutrition assessment of resident #009 completed by the RD and new actions to prevent weight loss were not documented in the nutrition care plan.

B) A review of resident #010's plan of care identified they were assessed as being a high nutrition risk. The documented weights showed resident #010 had a weight loss of 9.5 per cent with a decrease of 4.6 kilograms within 62 days. A review of the progress notes for an identified period of 25 days in 2015, showed there was no documented nutrition assessment of resident #010 completed by the RD and new actions to prevent weight loss were not documented in the nutrition care plan.

In an interview with the RD on an identified date in 2015, it was shared that they were aware resident #009 and #010 had had a weight change of more than 5 per cent or more in one month. It was confirmed that resident #009 and #010 weight change was not assessed by the RD using a multidisciplinary approach and new actions were not taken to try and prevent further weight loss. [s. 69. 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 residents with a change of 5 per cent of body weight, or more, over one month are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #4: 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. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no person simultaneously assists more than two residents who need total assistance with eating or drinking and no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

During a dining observation on and identified date in 2015, of the second meal service, resident's #005 and #303 were served their soup course and main course when no staff members were able to provide assistance. The resident's were observed to have their food plated in front of them for a time period greater than five minutes and were unable to feed themselves. During the service a PSW who was feeding resident's #301 and #302 who required total feeding assistance, left their table two times to provide total feeding assistance to resident's #005 and #303 who were sitting together at another table. Inspector #583 requested a Registered staff to come observe the dining service. The Registered staff confirmed that meals were served to resident's who required total assistance before staff were available to assist and that staff simultaneously assisted four resident's at one time who required total feeding assistance. The Registered staff confirmed there were not enough staff available in the dining room to provide the resident's with the level of assistance required during the meal service. [s. 73. (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 no person simultaneously assists more than two residents who need total assistance with eating or drinking and no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #5: 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).

Findings/Faits saillants :

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

On an identified date in 2015, resident #007 was observed wearing a physical device. A review of the plan of care identified the physical device was a restraint. LTC Inspector #583 was able to fit more than 4 finger widths between the residents hips and the physical device. A review of the manufacture's instructions for the physical device identified the device should be snug, but not interfere with breathing. The instructions identified to check for proper fit, staff should have been able to slide an open hand (flat) between the device and the resident. The Registered staff observed the application of resident #007's physical device on an identified date in 2015, and confirmed that resident #007's physical device was not applied as per the manufacturer's instructions. [s. 110. (1) 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 physical device is applied in accordance with the manufacturer's instructions, to be implemented voluntarily.

WN #6: 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. (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 has failed to ensure that the resident that was incontinent received an assessment using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident were required.

In May 2015, resident #010 was coded in MDS as being frequently incontinent of bladder and continent of their bowel. The resident had a decline in their condition over a three month period and in August 2015, the resident became frequently incontinent of their bowels.

A review of the resident's clinical record indicated that the resident had been coded in MDS as frequently incontinent of their bowels on an identified date in 2015. The resident did not receive an assessment designed for incontinence when there was a decline in the resident's continence level until 21 days later, which was a scheduled quarterly assessment.

It was confirmed during an interview by the RAI Coordinator on an identified date in 2015, that when the resident had a decline in their level of continence, the resident was not assessed using a clinically appropriate instrument specifically designed for assessment of continence. [s. 51. (2) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours.

Resident #005 had identified responsive behaviours. A review of the MDS coding for an identified period in 2015, indicated that a specified responsive behaviour occurred daily and occasionally other specified behaviours were demonstrated.

A review of the resident's plan of care indicated that strategies had not been developed and implemented to manage the resident's behaviours. Front line nursing staff interviewed on a specified date in 2015, verified that resident #005 did exhibit responsive behaviours as identified in the MDS coding.

It was confirmed by the RAI Coordinator on a specified date in 2015, that strategies had not been developed and implemented to respond to resident #005 who had been demonstrating responsive behaviours. [s. 53. (4) (b)]

Issued on this 4th day of December, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CATHY FEDIASH (214), KELLY HAYES (583), ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2015_248214_0024
Log No. / Registre no:	H-003451-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 2, 2015
Licensee / Titulaire de permis :	955464 ONTARIO LIMITED 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	CRESCENT PARK LODGE 4 Hagey Avenue, Fort Erie, ON, L2A-5M5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ROSEMARY TURNER

To 955464 ONTARIO LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (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 :

1. Review the falls plan of care for resident #005 and implement all falls prevention interventions.

2. Review all resident's plans of care who have been identified as a risk for falls and ensure that the falls prevention interventions have been implemented.

3. Conduct monthly audits to ensure that falls prevention interventions for residents at risk for falls are implemented as per their plans.

4. Provide education to all nursing staff on the home's process of implementing and removing falls prevention equipment such as chair and bed alarms, to ensure that falls prevention equipment is not removed from residents unless a falls reassessment indicates the intervention is no longer required.

Grounds / Motifs :

1. A) Previously identified as non-compliant with a CO on August 21, 2015.

B) On an identified date in 2015, resident #201 fell out of their wheelchair attempting to self-transfer to the toilet. The resident was transferred to hospital where it had been identified that the resident had sustained an identified injury. A review of the resident's clinical record indicated that the resident had been identified as a high risk for falls and specified fall prevention equipment had been implemented to minimize the risk of falls.

A review of the post fall assessment completed after this fall indicated that the resident's specified fall prevention equipment was on the resident's wheelchair at the time of the fall but it had not been turned on.

It was confirmed by documentation and during an interview with the DOC that the care set out in the plan of care had not been provided to the resident as specified in the plan.

PLEASE NOTE: This non-compliance was identified during a Critical Incident inspection, log #002386-15 conducted concurrently during the Resident Quality Inspection.

C) Resident #005 was identified as a high risk for falls on an identified date in 2015, and had sustained two falls on identified dates in 2015. A review of the resident's clinical record indicated that specified fall prevention equipment had been implemented when they were identified as a high risk for falls in 2015, to minimize the risk of falls.

On an identified date in 2015, the resident, was observed by the Long Term Care Homes (LTC) Inspector, sleeping in bed without the specified fall prevention equipment in place. A registered staff member was notified and had indicated that the specified fall prevention equipment had been on the resident's bed prior to this date; however; the specified fall prevention equipment was not in the resident's room and could not be located.

The staff member that manages the inventory and tracking of this specified fall prevention equipment was notified and indicated that they was not aware that the bed alarm had been removed.

It was confirmed during an interview with the RAI Coordinator that the care set out in the plan of care was not provided to the resident as specified in the plan. (508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 05, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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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 2nd day of December, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CATHY FEDIASH

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