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 prévue le Loi de 2007 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

Sudbury Service Area Office
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Mar 31, 2015;	2015_281542_0002 (A1)	S-000662-15	Resident Quality Inspection

Licensee/Titulaire de permis

F. J. DAVEY HOME
733 Third Line East Box 9600 Sault Ste Marie ON P6A 7C1

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

F. J. DAVEY HOME
733 Third Line East Sault Ste Marie ON P6A 7C1

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

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JENNIFER LAURICELLA (542) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance dates for orders # 001, 002, and 003 have been extended as requested by the Long-Term Care Home as follows;

1) Order #001 compliance date was extended to April 30, 2015

2) Order #002 compliance date was extended to April 24, 2015

3) Order #003 compliance date was extended to April 30, 2015

Issued on this 31 day of March 2015 (A1)

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

Original report signed by the inspector.

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JENNIFER LAURICELLA (542) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

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

Ministry of Health Logs inspected concurrently with the RQI: S-000114-4, S-000511-14, S-000501-13, S-000096-14, S-000528-14, S-000646-15, S-000014-14, S-000502-13, S-000503-13, S-000529-13, S-000505-14, S-000506-14, S-000338-14 and S-000507-15.

During the course of the inspection, the inspector(s) spoke with the Senior Administrator, Executive Director of Nursing (EDON), Director of Nursing, Registered Staff, Scheduling Staff, Director of Resident Services, RAI Coordinator, Registered Dietitian, Personal Support Worker (s), Resident Council, Family Council, Residents and Family Members.

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

Infection Prevention and Control

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.

15 WN(s)
11 VPC(s)
5 CO(s)
0 DR(s)
0 WAO(s)

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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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is an organized program of nursing

services and personal support services for the home to meet the assessed needs of the residents.

Inspector #595 spoke with scheduling staff #108 and requested a list of dates and resident home areas when there was not a full complement of Personal Support Workers (PSWs) and Registered Practical Nurses (RPNs) working from November 2014, until January 2015.

In the month of November 2014, Resident Home Areas (RHAs) were short staffed PSWs 19 times. Inspector #595 reviewed the Health Care Aide (HCA) Daily Flow Sheets for November 2014, for residents #066, #068 and #074. On one day, resident #074 was not offered a second bath. One week later, residents #066 and #068 were not offered a second bath.

In the month of December 2014, RHAs were short staffed PSWs 49 times. Of those times, on particular RHA was short staffed seven times. Inspector #595 reviewed the HCA Daily Flow Sheets for December for resident #069. On the same day in December there was not a full complement of PSWs resident #069 was not offered a bath.

In the month of January 2015, RHAs were short staffed PSWs 24 times.

Inspector #595 interviewed registered staff #109 who advised that if staff did not document a completed or refused bath/shower in the flow sheets, it cannot be assumed that it was completed and would be considered as 'not done'.

Inspector #595 spoke with PSW staff #110 who stated that if there is no documentation of a bath/shower in the flow sheets, it could be due to a lack of time to document. Another flow sheet that would show if a bath/shower was offered/provided was the 'Weekly Skin/Mouth Observation – HCA' sheet where staff document whether the bath was provided or refused and if any skin issues were present.

Inspector #595 reviewed the home's policy 'Personal Hygiene – Bathing Types' (CS-07-05-06) which stated that following care staff are to "complete the HCA Daily Flow sheet to indicate that the bath was given".

Inspector #595 reviewed additional HCA Daily flow sheets for residents #023, #058, #059, #060, #061, #062, #063, #064, #065, #068, #070, #072, #074, #075, #076. In the following weekly periods as dictated by the HCA Daily Flow Sheets, it was neither

documented in the Daily Flow Sheets nor the Weekly Skin/Mouth Observation sheet that a resident was offered a second bath/shower.

In the month of November 2014, there were eight instances where residents were not offered a second bath.

In the month of December 2014, there were 12 instances where residents were not offered a second bath.

In the month of January 2015, there were six instances where residents were not offered a second bath.

During the month of November 2014, RHAs were short staffed RPNs four times. Scheduling staff #108 stated that when there is a missing RPN on a RHA, a Charge Nurse is expected to fill in. Scheduling staff #108 identified that on one day in November 2014, there was no nurse (RPN or Charge Nurse) present on a night shift.

During the month of December 2014, RHAs were short on RPNs six times. Scheduling staff #108 identified that on two days in December 2014, there was no RPN on night shift.

During the month of January 2015, RHAs were short staffed RPNs seven times. Scheduling staff #108 identified that on three days in January 2015, there was no RPN on part of or on the entire evening shift. Scheduling staff #108 also reported that there is to be a full complement of staff at all times on a specific RHA. It was noted that on two occasions there was a shortage of PSWs and on one occasion there was no RPN on this specific RHA.

Inspector #595 spoke with registered staff # 111 who stated that if a treatment is not completed on the appropriate shift, staff on the next shift can complete the treatment and sign off on the Medication Administration Record (MAR) or Treatment Administration Record (TAR). Staff would communicate any missed treatments/medications in a progress note to alert oncoming staff, and that when the treatment/medication was completed staff were to make a note as well to document its completion.

Inspector #580 spoke with registered staff #111 who confirmed that events that are not documented have no proof of occurrence or completion, including treatments.

Throughout the RQI, Inspector #595 reviewed the shift report notes on various RHAs. In numerous instances, staff identified on the shift reports that treatments were not completed. Inspector #595 then looked at the specific resident's TAR and progress notes to determine if treatments were completed as prescribed.

On a day in December 2014, it was noted in the evening's section of the shift report that TARs were not completed for residents #062, #063, #082, #083, and #084. On this day, resident #062 did not receive two treatments, resident #063 did not receive one treatment, resident #082 did not receive one treatment, resident #083 did not receive three treatments, and resident #084 did not receive one treatment. Documentation by registered staff #114 for the missed treatments included 'did not get treatments done', 'treatment not done', 'did not get to these treatments'.

On another day in December, it was noted in the follow-up section of the shift report that resident #078's treatment was not completed. Inspector #595 reviewed the TAR for resident #078 which revealed a missing signature. Additionally, there was no progress note for this treatment on this particular day. Upon further review of resident #078's TAR, it was documented that the day prior, this resident did not receive two treatments. Registered staff #115 documented 'not this shift' for both treatments.

On a day in January, 2015, it was noted in the follow-up section of the shift report that treatments were not completed on residents #079, #080, and #081. On this day, resident #079 did not receive two treatments, resident #080 did not receive one treatment, and resident #081 did not receive one treatment. Documentation by staff included 'did not get to treatment today'.

It was also noted that resident #079 did not receive one treatment on a specific day in January, 2015. Registered staff #116 documented 'not able to complete treatment'. Additionally, it was discovered that resident #080 did not receive another treatment that same day, and did not receive a treatment the following day. Registered staff #116 documented 'unable to get treatment completed' and 'RPN not able to change dressing in the am please address on evening shift'. It was evident in the TAR that another staff member did not sign off for the treatment on the second day, thus indicating that it was not addressed on another shift. According to the TAR, resident #080 did not receive treatment for three days.

On another day in January,2015, it was noted on the evenings report that resident #073's three treatments were not completed. Inspector #595 reviewed the January 2015, TAR for resident #073 which showed documentation that the nurse had linked a

note to the treatment. Registered staff #114 documented 'could not get to res dressing, helping finish med pass on other units', 'not able to get to resident treatments, helping cover on other units'.

Inspector #595 reviewed the shortage staffing list as provided by scheduling staff #108. It was evident that on a day in January,2015, a neighbouring RHA did not have an RPN on shift. Inspector #595 spoke with registered staff #114 who confirmed that the treatments were not completed that day due to short staffing, which required them to cover the neighbouring RHA.

Upon further review of resident #073's TAR, it was noted that the same three treatments were not completed two days later. It was documented in the progress notes by registered staff #114 'could not get to treatment this evening'.

On January 28, 2015, Inspector #595 entered a resident dining room at 1710h. All four residents at one table, #054, #055, #056, #057, had been served their dinner. All four of these residents required total assistance from staff with eating. PSW staff #117 approached residents #055 and #056 and started to feed them. A few minutes later, the staff member went to feed resident #057, and returned back and forth to residents #055 and #056. PSW staff #117 then stood up and attempted to feed resident #054, who would not wake up at the table.

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 003

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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 has failed to ensure that the care is provided to resident #002, #013, #033 and #036 as specified in the plan of care.

Inspector #603 completed a health record review for resident #002 which concluded that the resident suffered a fall and was found on the floor with bare feet and no posey hip protectors on.
On January 28, 2015, Inspector #603 reviewed resident #002's care plan which indicated that the resident was to wear posey hip protectors at all times and non-slip socks at night to prevent falls.
On January 28, 2015, Inspector #603 observed resident #002 sitting in their wheelchair with no posey hip protectors on, nor did the resident have any in their room. Personal Support Worker (PSW) #101 confirmed to the inspector that the resident did not have posey protectors on.
On January 28, 2015, Inspector #603 interviewed PSW staff #101 and #102, and both stated that the resident never wears the posey hip protectors or the non-slip socks. [s. 6. (7)]

2. On January 22, 2015, Inspector #580 reviewed the care plan for resident #013, revised on August 29, 2014, which indicated that one staff was to provide the resident with oral care, using the resident's toothbrush and toothpaste and not to use mouthwash.
On January 22, 2015, PSW staff #105 and #106 confirmed to Inspector #580 that they use the care plan for direction and that the mouth care for resident #013 includes swabbing with mouthwash and not to use a toothbrush. [s. 6. (7)]

3. On January 29, 2015, Inspector #542 completed a health record review for resident #033. The most current care plan available to the direct care staff indicated that the resident was to be up for meals only and then placed back to bed to relieve pressure and that the resident was to be repositioned hourly when up in their wheelchair and in bed. Inspector #542 interviewed PSW staff #103 and #104 who both informed this inspector that the resident is either repositioned every 1 1/2 - 2 hours and that the resident is occasionally put back to bed for rest periods. PSW staff #103 further stated that the resident had been up since breakfast. Inspector #542 observed resident #033 in their wheelchair at 1030 hrs and PSW staff #104 confirmed that the resident had not been transferred back to bed after breakfast. [s. 6. (7)]

4. On January 28, 2015, Inspector #603 reviewed a Critical Incident (CI) that was submitted to the Director. The CI was submitted due to a fracture that resident #003 sustained. Upon the home's investigation it was revealed that PSW #135 transferred resident #003 without using the mechanical lift. Inspector #603 reviewed resident #003's care plan dated November 6, 2013, which indicated: staff were to use the lift to transfer the resident in and out of bed. The CI also indicated that the PSW #135 admitted to not reading or following the care plan and transferred the resident with one person assist and did not use the mechanical lift. This PSW staff was terminated from their employment. [s. 6. (7)]

5. The licensee has failed to ensure that resident #033 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.

On January 29th, 2015, Inspector #542 completed a health record review for resident #033. The most recent care plan accessible to the direct care staff indicated that the resident had a stage 2 pressure ulcer. This section of the care plan was last updated on September 19, 2014. The most recent RAI-MDS assessment indicated that the resident had a stage 2 pressure ulcer. Inspector #542 interviewed registered staff #107 and was informed that the resident's pressure ulcer had improved. The registered staff also stated that the care plan should have been revised once the pressure ulcer improved. [s. 6. (10) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

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 is 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 #9: The Licensee has failed to comply with LTCHA, 2007, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that they respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

On January 29, 2015, at 1400 hrs, Inspector #603 met with the Chair of the Family Council who explained that the home does not always respond in writing to the Family Council's concerns or questions within 10 days. The Chair produced a document dated December, 2014, that stated that the assistant sent the minutes and the concerns' list to the Home's Management Team and Board Chair in September, 2014, and again on October, 2014, as no responses were received. As of the December, 2014, meeting, no responses had been received. On a day in January, 2015, Inspector #603 met with the Assistant to the Family Council who is also the Chaplain of the home who confirmed that the home does not always respond to the concerns or recommendations, in writing within 10 days. [s. 60. (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 to respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 67. s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to consult regularly with the Family Council, and in any case at least every three months.

On January 29, 2015, at 1400 hrs, Inspector #603 met with the Chair of the Family Council, who explained that the home never consults with the Family Council. In fact, they have brought these concerns forward to administration and to the Board of Directors. The Chair also explained that things have gotten worse since the home has "been taken over by consultants" where they have no say. The chair gave the example of not being able to give recommendations on a satisfaction survey.

Inspector #603 reviewed the minutes from December 9, 2014. The minutes indicated that the Assistant to the Family Council sent their concerns to the home's management team and the Board Chair in September, 2014, and October, 2014, and to this date no responses have been received. [s. 67.]

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 licensee consults at least every three months with the Residents' Council and Family Council, to be implemented voluntarily.

WN #11: 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 the Disposal of Discontinued/Expired Drugs, Narcotics and Controlled Substances -04-08-10 and Procedure for the Disposition of Used Fentanyl Patches – CS-13-05-07 policies are complied with.

On January 22, 2015, Inspector #580 reviewed the Home's Disposal of Discontinued/Expired Drugs, Narcotics and Controlled Substances -04-08-10 reviewed July 25, 2014, and Procedure for the Disposition of Used Fentanyl Patches – CS-13-05-07 reviewed December 2013. Which indicated that discontinued narcotics and controlled substances are placed in the double locked centralized storage area within the facility (i.e. wooden narcotic box). The policies also indicate that narcotics and controlled substances are to be destroyed by a member of the registered staff and the pharmacist on site, and that medications are not to be disposed of in sharps containers.

On January 27, 2015, the Executive Director of Nursing (EDON) confirmed to Inspector #580 that RPNs bring the discarded/discontinued narcotics to the EDON's office, place the narcotics in the slotted, locked, secure wooden container for Narcotic/Controlled Drug Disposal located in the EDON's office. The EDON confirmed to the inspector that she or delegate is able to unlock the wooden container for Narcotic/Controlled Drug Disposal box by herself, that it is single locked in the EDON office. The Director of Nursing and the EDON both confirmed to the inspector that the discontinued or surplus narcotic patches are disposed of in the Sharps containers and either returned to the nursing units by registered staff until the Sharps Containers are full or brought by the RHA clerk or maintenance staff to the storage room in the basement. [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, strategy or system put in place specifically pertaining to the polices and procedures related to Narcotic and Controlled Substances are complied with, to be implemented voluntarily.

WN #14: 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 is notified within 12 hours of the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

On January 22, 2015, Inspector #542 reviewed a Critical Incident (CI) report that was submitted to the Director. It indicated that a staff member #127 was being accused of abuse towards resident #053. This was reported to the DON #112 by staff member #128. The CI also indicated that the licensee did not contact the resident's SDM and that the home would contact the family post investigation. Inspector #542 interviewed the DON and was informed that the home did not notify the family at any time. [s. 97. (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 the resident's substitute decision-maker, if any, and any other person specified by the resident is notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: a response shall be made to the person who made the complaint indicating what the licensee has done to resolve the complaint, or that the licensee believes the complaint to be unfounded and the reasons for the disbelief.

A family member for resident #040 submitted a complaint to the licensee and in turn the licensee submitted a Critical Incident (CI) to the Director. The CI indicated that a staff member was abusive towards resident #040. Resident #040 had stated that the staff member refused to assist them with their needs. The licensee completed an investigation and the found that the allegations could not be substantiated.

On January 27, 2015, Inspector #542 spoke with the Director of Resident and Staff Services who provided this inspector with a copy of the original complaint. On January 28, 2015, Inspector spoke with the Director of Nursing at the time of the incident and was informed that she was not involved in any response letter that was sent to the family/resident with regards to how the home dealt with the complaint. Inspector also spoke with the Senior Administrator who could not locate a copy of the letter of response to the family. [s. 101. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with by providing a response to the person who made the complaint explaining what the licensee has done to resolve the complaint or that the licensee believes the complaint to be unfounded and the reasons for the belief, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Registered Dietitian who is a member of the staff of the home completed a nutritional assessment for resident #054 when there was a significant change in the resident's health condition and assess the resident's nutritional status, including height, weight, any risks related to nutrition care, hydration status, and any risks related to hydration.

Inspector #595 reviewed a complaint that was submitted to the Director, which indicated concerns pertaining to resident #054's nutritional status.
Inspector #595 reviewed the health care record for resident #054 and it was noted that the resident a significant weight loss over a two month period.

Inspector #595 spoke with registered staff #120 who informed Inspector that when a resident has a significant weight loss, registered staff are to complete the 'Hydration Assessment - Nursing' in PointClickCare. Additionally, staff are to complete the 'EO Nutrition - Referral to Registered Dietitian' (RD) assessment to refer the resident to the RD in the home. Registered staff #120 continued to explain that when the weights are input into PointClickCare, it automatically generates whether there was significant weight loss based upon previous months.

Inspector #595 reviewed the completed assessments on PointClickCare for resident #054. During this two month period there were no assessments or referrals to the RD completed specifically pertaining to resident #054's 9.6kg weight loss. Inspector #595 spoke with the Registered Dietitian who confirmed that they did not complete a nutritional assessment on resident #054 until the next month. [s. 26. (4) (a),s. 26. (4) (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 a registered dietitian completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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 has failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Inspector # 542 reviewed a Critical Incident (CI) that was submitted. The CI indicated that registered staff #124 was overheard threatening resident #035 if they didn't stop being rude. Inspector reviewed the employee's personal file which included two separate incidents where registered staff #124 was abusive towards resident #035. On both occasions the registered staff was instructed to read their professional standards and further incidents of abuse towards residents could result in further discipline.
The licensee discharged registered staff #124 from employment at the home during the investigation of the Critical Incident that was submitted to the Director. [s. 19. (1)]

2. On January 22, 2015, Inspector # 542 reviewed Critical Incident (CI) that was submitted to the Director. The CI was submitted in regards to staff to resident abuse. The CI indicated that resident #039 reported that Personal Support Worker #136 had been abusive towards them and wanted to steal their belongings. The licensee completed an investigation which further identified that resident #039 did not want this PSW staff to care for them anymore and PSW staff #136 was terminated. On Janurary 28, 2015, Inspector #542 reviewed PSW staff #136's employee file, the letter of termination indicated that staff member's actions were not in keeping with the resident's wishes and were a breach of the residents rights to be free from abuse. [s. 19. (1)]

Additional Required Actions:

CO # - 005 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. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's condition is reassessed and the effectiveness of the restraining evaluated by a registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

On January 22, 2015, at 1518 hrs, Inspector #603 interviewed registered staff #125 who explained that staff do not reassess resident's condition and the restraint's effectiveness, at least every eight hours while a resident is restrained. The staff explained that this reassessment is only done on the quarterly evaluations. On January 27, 2015, at 1115 hrs, Inspector interviewed registered staff #126 who explained that the registered staff do not assess the resident's response to the restraint and the need for continued usage of restraint each shift. The staff also explained that this is only completed on the quarterly evaluation.

On January 22, 2015, at 1535 hrs, Inspector #603 interviewed registered staff #119, who could not explain the home's expectation around residents' regular reassessment and documentation of restraints. The staff explained that the PSWs document on the Restraint Record that the restraint is being utilized according to the physician's order and the RPNs sign off on the MAR that the resident is restrained as per physician's order. The staff explained that any reassessment of restraint is only completed in PCC when the quarterly evaluation is completed.

Inspector #603 reviewed the Physical Restraint policy dated November 2012, which indicated under Evaluation: 1. At a minimum, the resident's response to the restraint and the need for continued use of the restraint must be evaluated each shift and documented either on the Restraint Record, or where e-documentation is in place. This is not being done.

While interviewing registered staff #125 and #126, both staff explained that they are not aware as to why they have to check off every morning at 0700 hrs about the tilted chair as a restraint. They both thought that it was a reminder that the resident has a tilted wheelchair as a restraint.

Inspector #603 reviewed the resident's care plan on Physical Restraint: Tilt Wheelchair and it did not indicate regular evaluations, however it indicated the need for reassessment in 3 months (January 1, 2015). [s. 110. (2) 6.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 004

WN #13: 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 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.

On January 21, 2015, registered staff #123 confirmed to Inspector #580 that discontinued and used Fentanyl patches are placed in the sharps containers which are returned by the ward clerk who brings these to the storage room in the basement for removal by the pharmacy's drug disposal company. Director of Nursing #118 and the EDON confirmed to the inspector that the discontinued or surplus narcotic patches are disposed of in the Sharps containers and either returned to the nursing units by registered staff until the Sharps Containers are full or brought by the RHA clerk or maintenance staff to the storage room in the basement.

On January 22, 2015, at 1040 hrs, Inspector #580 observed the home's drug storage room on first floor Cedar with registered staff #123 and observed the discontinued/discarded medication containers. On January 27, 2015, the maintenance person, confirmed to the inspector that the maintenance staff have the key to the storage room. The inspector observed that the storage room contained numerous sharps containers awaiting pick-up by the home's disposal company.

On January 27, 2015, the EDON and the DON confirmed to the inspector that the RPN brings the discarded/discontinued narcotics to the EDON's office and the discarded/discontinued narcotics are placed in the slotted, locked, secure wooden container for Narcotic/Controlled Drug Disposal located in the EDON's office. On January 27, 2015, the EDON and DON confirmed to the inspector that they or a delegate is able to unlock the wooden container for Narcotic/Controlled Drug Disposal box by themselves, that the wooden container is single locked in the locked EDON office. [s. 129. (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 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On January 27, 2015, Inspector #595 spoke with registered staff #111 who stated that if a treatment is not completed on the appropriate shift, staff on the next shift can complete the treatment and sign off on the Medication Administration Record (MAR) or Treatment Administration Record (TAR). Staff would communicate any missed treatments/medications in a progress note to alert oncoming staff, and that when the treatment/medication was completed staff were to make a note as well to document its completion. On January 28, 2015, Inspector #580 spoke with registered staff #112 who confirmed that events not documented, have no proof of occurrence or completion, including prescribed treatments.

Throughout the Resident Quality Inspection (RQI) Inspector #595 reviewed the shift report notes over a three month period, on various resident home areas. In numerous instances, staff identified on the shift reports that treatments were not completed. Inspector #595 then looked at the specific resident's TAR and progress notes to determine if treatments were completed as prescribed. In January, 2015, Inspector #595 spoke with registered staff #113 who confirmed that registered staff can only implement monitoring interventions (which would be added to the TAR), whereas all other orders are prescribed by a physician or nurse practitioner.

Inspector #595 reviewed a shift report on a specific RHA and noted that a registered staff had documented that a prescribed treatment was not completed for resident #083. Inspector #595 reviewed the TAR for resident #083 and noted that the resident had a physician's order for a medicated balm to be applied three times a day. Inspector #595 reviewed the progress notes for resident #083 regarding the medicated balm. Registered staff # 114 documented that they did not get to the third application of the treatment and that the charge was aware.

Inspector # 595 reviewed resident # 078's TAR, and it was noted that on a day in December, the resident did not receive their the prescribed treatment that was ordered, three times daily. Inspector #595 reviewed the progress notes for this prescribed treatment and it was documented by staff #115 'not this shift'.

On a different day, it was noted in the follow-up section of the shift report that treatments were not completed for residents #079 and #081. Inspector #595 reviewed the TAR for resident #079 which noted that the resident had an order for a topical medication to be applied daily. In a progress note a registered staff documented that they were not able to get to treatment that day.

Inspector #595 reviewed the TAR for resident #081 which indicated an order for a topical medication to be applied daily. Upon review of the progress notes a registered staff documented that the application of the topical medication was not completed.

Inspector #595 reviewed an evening shift report that indicated that resident #073's topical medication treatments were not completed. Inspector #595 reviewed the TAR for resident #073. It was documented that three of the prescribed topical medications were not administered. Upon further review of the progress notes for this resident it was noted that registered staff # 114 documented that they could not get to resident's treatments as they were helping to finish medications on other units.

Inspector #595 spoke with registered staff #114 who confirmed that the treatments were not completed on January 18, 2015 due to short staffing, which required her to cover other units. Upon further review of resident #073's TAR, it was noted that the same three treatments were not completed on January 16, 2015. It was documented in the progress notes by registered staff #114 "could not get to treatment this evening". [s. 131. (2)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On January 23, 2015, Inspector #542 observed staff member #129 and # 130 on a resident home area. Both staff members were providing direct care to a resident #042 who was on Contact Precautions. The signage on the resident's door indicated that the staff were to wear appropriate personal protective equipment. Both staff members were observed by this inspector to not be wearing a gown while providing direct care. Inspector asked both staff members if they were supposed to be wearing a gown while providing direct care, both staff members stated that yes they were supposed to wear a gown but they just didn't. Inspector #542 reviewed the resident's most recent care plan available to the direct care staff, in which it indicated that staff where to wear a gown and gloves for direct care.

On January 26th, 2015, Inspector #542 observed staff member #131 and #132 assisting resident #041 with toileting. The staff member brought the mechanical lift in the room to transfer the resident from bed to toilet. Both staff members proceeded with the activity without applying a gown, according to the signage on the door indicating that the resident was on Contact Precautions and gowns and gloves where to be worn. Once the toileting activity was completed, the one staff member brought the lift out into the hallway for someone else to use, no cleaning of the lift was completed. Inspector asked staff member #131 if they were required to wear the PPE stated that they were unsure. The other PSW staff member stated that they believed they were only to wear gloves and then proceeded to ask registered staff #133, who confirmed that the staff are only to wear gloves when providing direct care. Inspector reviewed the residents care plan which indicated that gloves and a gown is to be worn. The Infection Prevention and Control Lead informed this Inspector that the staff are required to wear gloves and gown for residents on Contact Precautions when they are providing direct care. [s. 229. (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 all staff participate in the implementation of the infection prevention and control program by wearing the appropriate personal protective equipment, to be implemented voluntarily.

WN #7: 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 has failed to ensure that residents with significant weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

Inspector #595 reviewed a complaint that was submitted to the Director, which indicated concerns pertaining to resident #054's nutritional status.
Inspector #595 reviewed the health care record for resident #054, it was noted that the resident had a significant weight loss over a two month period.

Inspector #595 spoke with registered staff #120 who informed Inspector that when a resident has a significant weight loss, registered staff are to complete the 'Hydration Assessment - Nursing' on PointClickCare. Additionally, staff are to complete the 'EO Nutrition - Referral to Registered Dietitian' (RD) assessment to refer the resident to the RD in the home. Registered staff #120 continued on to explain that when the weights are input into PointClickCare, it automatically generates whether there was significant weight loss based upon previous months.

The home's policy 'Weight Change Program (RESI-05-02-07)' which indicated that the role of the interdisciplinary team is to record a summary of weight discussions in the resident progress notes. Inspector #595 reviewed the progress notes from September to December 2014, and no notes were created pertaining to an interdisciplinary meeting about resident #054's significant weight change.

Inspector #595 reviewed the completed assessments in PointClickCare for resident #054. During this two month period there were no assessments or referrals to the RD completed specifically pertaining to resident #054's significant weight loss. Inspector #595 spoke with the Registered Dietitian who confirmed that they did not complete a nutritional assessment on resident #054 until the next month. The staff member also mentioned that there is no interdisciplinary approach to assess residents experiencing significant weight loss. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 residents with significant weight changes were assessed using an interdisciplinary approach and that actions were taken and outcomes were evaluated, to be implemented voluntarily.

WN #10: 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).

s. 73. (2) The licensee shall ensure that,
(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 has failed to ensure that staff members assist only one or two residents at the same time who need total assistance with eating or drinking.

On January 28, 2015, Inspector #595 entered a dining room on the first floor at 1710h. All four residents, #054, #055, #056, #057 were seated at table 5 with their plated dinner, and all of whom required total assistance with eating. Staff member #117 approached residents #055 and #056 started to feed them. A few minutes later, the staff member started to feed resident #057, and returned back and forth to residents #055 and #056. Staff member #117 then stood up and attempted to feed resident #054, who would not wake up at the table. [s. 73. (2) (a)]

2. The licensee has failed to ensure that residents who require assistance with eating or drinking only served a meal when someone is available to provide the assistance.

On January 28, 2015, Inspector #595 observed dinner service on a RHA. Inspector arrived on the unit at 1710 hrs and noted that all four residents at a table had been served their dinner and no staff were present at the table. All of these residents required total eating assistance from staff. At 1714 hrs resident #055 was approached by staff member #117 who began to feed the resident, then moved to resident #056. Staff member #117 then proceeded to feed resident #057 at 1716 hrs after the other two residents. Resident #054 was not offered assistance with eating by a staff member #117 until 1720h.

The licensee has failed to ensure that residents #054, #055, #056 and #057 were served a meal when someone was available to provide assistance. [s. 73. (2) (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 staff members assist only one or two residents at the same time who need total assistance with eating or drinking and that they are only served a meal when someone is available to provide assistance, to be implemented voluntarily.

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 prévue le Loi de 2007 les foyers de soins de longue durée

Issued on this 31 day of March 2015 (A1)

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

Ministère 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

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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
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Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JENNIFER LAURICELLA (542) - (A1)

Inspection No. / No de l'inspection : 2015_281542_0002 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : S-000662-15 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Mar 31, 2015;(A1)

Licensee / Titulaire de permis : F. J. DAVEY HOME
733 Third Line East, Box 9600, Sault Ste Marie, ON, P6A-7C1

LTC Home / Foyer de SLD : F. J. DAVEY HOME
733 Third Line East, Sault Ste Marie, ON, P6A-7C1

Ontario

Ministry of Health and Long-Term Care

Ministère 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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : PETER J. MACLEAN

To F. J. DAVEY HOME, 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, 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 ensure that the care set out in the plan of care is provided to the resident as specified in the plan and shall prepare, submit and implement a plan for achieving compliance with s. 6. (7). The compliance plan shall include how the licensee will ensure that the care set out in the plan of care is provided as specified in the plan for resident #002, 033, 013, 003, and all residents of the home.

The plan shall be submitted in writing to Jennifer Lauricella, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564-3133. The plan must be submitted by March 27, 2015.

Grounds / Motifs :

1. Six previous Written Notifications (WN) of non-compliance under the LTCHA, 2007 S.O. 2007, c.8, s. 6. (7). Including six Compliance Orders (CO) issued in January 2012 during inspection #2012_099188_0005, April 2012 during inspection #2012_099188_0015, July 2012 during inspection #2012_099188_0027, April 2013 during inspection #2012_104196_0033, May 2013 during inspection 2013_139163_005 and March 2014 during inspection #2014_281542_0004.

The licensee shall ensure that the care set out in the plan of care is provided to resident # 003, # 033, # 013 and # 002 as specified in the plan.

On January 28, 2015, Inspector #603 reviewed a Critical Incident (CI) that was submitted to the Director. The CI was submitted due to a fracture that resident #003 sustained. Upon the home's investigation it was revealed that PSW #135 transferred resident #003 without using the mechanical lift. Inspector #603 reviewed resident #003's care plan dated November 6, 2013, which indicated: staff were to use the lift to transfer the resident in and out of bed. The CI also indicated that the PSW #135 admitted to not reading or following the care plan and transferred the resident with one person assist and did not use the mechanical lift. This PSW staff was terminated from their employment. [s. 6. (7)]
(603)

2. On January 29, 2015, Inspector #542 completed a health record review for resident #033. The most current care plan available to the direct care staff indicated that the resident was to be up for meals only and then placed back to bed to relieve pressure and that the resident was to be repositioned hourly when up in their wheelchair and in bed. Inspector #542 interviewed PSW staff #103 and #104 who both informed this inspector that the resident is either repositioned every 1 1/2 - 2 hours and that the resident is occasionally put back to bed for rest periods. PSW staff #103 further stated that the resident had been up since breakfast. Inspector #542 observed resident #033 in their wheelchair at 1030 hrs and PSW staff #104 confirmed that the resident had not been transferred back to bed after breakfast.
(542)

3. On January 22, 2015, Inspector #580 reviewed the care plan for resident #013, revised on August 29, 2014, which indicated that one staff was to provide the resident with oral care, using the resident's toothbrush and toothpaste and not to use mouthwash.
On January 22, 2015, PSW staff #105 and #106 confirmed to Inspector #580 that they use the care plan for direction and that the mouth care for resident #013 includes swabbing with mouthwash and not to use a toothbrush. (580)

4. IInspector #603 completed a health record review for resident #002 which concluded that the resident suffered a fall and was found on the floor with bare feet and no posey hip protectors on.
On January 28, 2015, Inspector #603 reviewed resident #002's care plan which indicated that the resident was to wear posey hip protectors at all times and non-slip socks at night to prevent falls.
On January 28, 2015, Inspector #603 observed resident #002 sitting in their wheelchair with no posey hip protectors on, nor did the resident have any their room. Personal Support Worker (PSW) #101 confirmed to the inspector that the resident did not have posey protectors on.
On January 28, 2015, Inspector #603 interviewed PSW staff #101 and #102, and both stated that the resident never wears the posey hip protectors or the non-slip socks.
(603)

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

Apr 30, 2015(A1)

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2014_281542_0017, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber and shall prepare, submit and implement a plan for achieving compliance with the requirement that ensures that drugs are administered to all residents, in accordance with directions for use specified by the prescriber.

The plan shall be submitted in writing to Jennifer Lauricella, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564-3133. This plan must be submitted by March 27, 2015.

Grounds / Motifs :

1. Three previous Written Notifications (WN) were issued under O.Reg. 79/10, s.131 (2). Including three Compliance Orders (CO) in April 2013 during inspection 2012_104196_0033, August 2013 during inspection 2013_139163_0020 and January 2014 during inspection 2013_279540_0003.

The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On January 27, 2015, Inspector #595 spoke with registered staff #111 who stated that if a treatment is not completed on the appropriate shift, staff on the next shift can

complete the treatment and sign off on the Medication Administration Record (MAR) or Treatment Administration Record (TAR). Staff would communicate any missed treatments/medications in a progress note to alert oncoming staff, and that when the treatment/medication was completed staff were to make a note as well to document its completion. On January 28, 2015, Inspector #580 spoke with registered staff #112 who confirmed that events not documented, have no proof of occurrence or completion, including prescribed treatments.

Throughout the Resident Quality Inspection (RQI) Inspector #595 reviewed the shift report notes over a three month period, on various resident home areas. In numerous instances, staff identified on the shift reports that treatments were not completed. Inspector #595 then looked at the specific resident's TAR and progress notes to determine if treatments were completed as prescribed. On January 30, 2015, Inspector #595 spoke with registered staff #113 who confirmed that registered staff can only implement monitoring interventions (which would be added to the TAR), whereas all other orders are prescribed by a physician or nurse practitioner.

Inspector #595 reviewed a shift report on a specific RHA and noted that a registered staff had documented that a prescribed treatment was not completed for resident #083. Inspector #595 reviewed the TAR for resident #083 and noted that the resident had a physician's order for a medicated balm to be applied three times a day. Inspector #595 reviewed the progress notes for resident #083 regarding the medicated balm. Registered staff # 114 documented that they did not get to the third application of the treatment and that the charge was aware.

Inspector # 595 reviewed resident # 078's TAR, and it was noted that on day in December, the resident did not receive their the prescribed treatment that was ordered, three times daily. Inspector #595 reviewed the progress notes for this prescribed treatment and it was documented by staff #115 'not this shift'.

On a different day, it was noted in the follow-up section of the shift report that treatments were not completed for residents #079 and #081. Inspector #595 reviewed the TAR for resident #079 which noted that the resident had an order for a topical medication to be applied daily. In a progress note a registered staff documented that they were not able to get to treatment that day.

Inspector #595 reviewed the TAR for resident #081 which indicated an order for a topical medication to be an applied daily. Upon review of the progress notes a

registered staff documented that the application of the topical medication was not completed.

Inspector #595 reviewed an evening shift report that indicated that resident #073's topical medication treatments were not completed. Inspector #595 reviewed the TAR for resident #073. It was documented that three of the prescribed topical medications were not administered. Upon further review of the progress notes for this resident it was noted that registered staff # 114 documented that they could not get to resident's treatments as they were helping to finish medications on other units.

Inspector #595 spoke with registered staff #114 who confirmed that the treatments were not completed on January 18, 2015 due to short staffing, which required her to cover other units. Upon further review of resident #073's TAR, it was noted that the same three treatments were not completed on January 16, 2015. It was documented in the progress notes by registered staff #114 "could not get to treatment this evening". [s. 131. (2)] (595)

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

Apr 24, 2015(A1)

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Order / Ordre :

(A1)
The licensee shall ensure that there is an organized program of nursing services and personal support services to ensure that all residents are offered a bath shower twice weekly, receive the prescribed skin wound treatments as ordered and are assisted with feeding in a manner that supports the required legislation. The licensee shall also prepare, submit and implement a plan for achieving compliance and shall include specified time frames for the development and implementation and identify the staff member(s) responsible for the implementation.

The plan shall be submitted in writing to Jennifer Lauricella, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564-3133. The plan must be submitted by March 27, 2015.

Grounds / Motifs :

1. A previous Voluntary Plan of Correction (VPC) was issued under LTCHA, 2007 S.O. 2007, c.8, s.8 in July 2014 during inspection 2014_281542_0016.

The licensee has failed to ensure that there is an organized program of nursing services and personal support services for the home to meet the assessed needs of the residents.

Inspector #595 spoke with scheduling staff #108 and requested a list of dates and resident home areas when there was not a full complement of Personal Support Workers (PSWs) and Registered Practical Nurses (RPNs) working from November

2014, until January 2015.

In the month of November 2014, Resident Home Areas (RHAs) were short staffed PSWs 19 times. Inspector #595 reviewed the Health Care Aide (HCA) Daily Flow Sheets for November 2014, for residents #066, #068 and #074. On one day, resident #074 was not offered a second bath. One week later, residents #066 and #068 were not offered a second bath.

In the month of December 2014, RHAs were short staffed PSWs 49 times. Of those times, on particular RHA was short staffed seven times. Inspector #595 reviewed the HCA Daily Flow Sheets for December for resident #069. On the same day in December there was not a full complement of PSWs resident #069 was not offered a bath.

In the month of January 2015, RHAs were short staffed PSWs 24 times.

Inspector #595 interviewed registered staff #109 who advised that if staff did not document a completed or refused bath/shower in the flow sheets, it cannot be assumed that it was completed and would be considered as 'not done'.

Inspector #595 spoke with PSW staff #110 who stated that if there is no documentation of a bath/shower in the flow sheets, it could be due to a lack of time to document. Another flow sheet that would show if a bath/shower was offered/provided was the 'Weekly Skin/Mouth Observation – HCA' sheet where staff document whether the bath was provided or refused and if any skin issues were present.

Inspector #595 reviewed the home's policy 'Personal Hygiene – Bathing Types' (CS-07-05-06) which stated that following care staff are to "complete the HCA Daily Flow sheet to indicate that the bath was given".

Inspector #595 reviewed additional HCA Daily flow sheets for residents #023, #058, #059, #060, #061, #062, #063, #064, #065, #068, #070, #072, #074, #075, #076. In the following weekly periods as dictated by the HCA Daily Flow Sheets, it was neither documented in the Daily Flow Sheets nor the Weekly Skin/Mouth Observation sheet that a resident was offered a second bath/shower.

In the month of November 2014, there were eight instances where residents were not offered a second bath.

In the month of December 2014, there were 12 instances where residents were not offered a second bath.

In the month of January 2015, there were six instances where residents were not offered a second bath.

During the month of November 2014, RHAs were short staffed RPNs four times. Scheduling staff #108 stated that when there is a missing RPN on a RHA, a Charge Nurse is expected to fill in. Scheduling staff #108 identified that on one day in November 2014, there was no nurse (RPN or Charge Nurse) present on a night shift.

During the month of December 2014, RHAs were short on RPNs six times. Scheduling staff #108 identified that on two days in December 2014, there was no RPN on night shift.

During the month of January 2015, RHAs were short staffed RPNs seven times. Scheduling staff #108 identified that on three days in January 2015, there was no RPN on part of or on the entire evening shift. Scheduling staff #108 also reported that there is to be a full complement of staff at all times on a specific RHA. It was noted that on two occasions there was a shortage of PSWs and on one occasion there was no RPN on this specific RHA.

Inspector #595 spoke with registered staff # 111 who stated that if a treatment is not completed on the appropriate shift, staff on the next shift can complete the treatment and sign off on the Medication Administration Record (MAR) or Treatment Administration Record (TAR). Staff would communicate any missed treatments/medications in a progress note to alert oncoming staff, and that when the treatment/medication was completed staff were to make a note as well to document its completion.

Inspector #580 spoke with registered staff #111 who confirmed that events that are not documented have no proof of occurrence or completion, including treatments.

Throughout the RQI, Inspector #595 reviewed the shift report notes on various RHAs. In numerous instances, staff identified on the shift reports that treatments were not completed. Inspector #595 then looked at the specific resident's TAR and

progress notes to determine if treatments were completed as prescribed.

On a day in December 2014, it was noted in the evening's section of the shift report that TARs were not completed for residents #062, #063, #082, #083, and #084. On this day, resident #062 did not receive two treatments, resident #063 did not receive one treatment, resident #082 did not receive one treatment, resident #083 did not receive three treatments, and resident #084 did not receive one treatment. Documentation by registered staff #114 for the missed treatments included 'did not get treatments done', 'treatment not done', 'did not get to these treatments'.

On another day in December, it was noted in the follow-up section of the shift report that resident #078's treatment was not completed. Inspector #595 reviewed the TAR for resident #078 which revealed a missing signature. Additionally, there was no progress note for this treatment on this particular day. Upon further review of resident #078's TAR, it was documented that the day prior, this resident did not receive two treatments. Registered staff #115 documented 'not this shift' for both treatments.

On a day in January, 2015, it was noted in the follow-up section of the shift report that treatments were not completed on residents #079, #080, and #081. On this day, resident #079 did not receive two treatments, resident #080 did not receive one treatment, and resident #081 did not receive one treatment. Documentation by staff included 'did not get to treatment today'.

It was also noted that resident #079 did not receive one treatment on a specific day in January, 2015. Registered staff #116 documented 'not able to complete treatment'. Additionally, it was discovered that resident #080 did not receive another treatment that same day, and did not receive a treatment the following day. Registered staff #116 documented 'unable to get treatment completed' and 'RPN not able to change dressing in the am please address on evening shift'. It was evident in the TAR that another staff member did not sign off for the treatment on the second day, thus indicating that it was not addressed on another shift. According to the TAR, resident #080 did not receive treatment for three days.

On another day in January,2015, it was noted on the evenings report that resident #073's three treatments were not completed. Inspector #595 reviewed the January 2015, TAR for resident #073 which showed documentation that the nurse had linked a note to the treatment. Registered staff #114 documented 'could not get to res dressing, helping finish med pass on other units', 'not able to get to resident

treatments, helping cover on other units'.

Inspector #595 reviewed the shortage staffing list as provided by scheduling staff #108. It was evident that on a day in January,2015, a neighbouring RHA did not have an RPN on shift. Inspector #595 spoke with registered staff #114 who confirmed that the treatments were not completed that day due to short staffing, which required them to cover the neighbouring RHA.

Upon further review of resident #073's TAR, it was noted that the same three treatments were not completed two days later. It was documented in the progress notes by registered staff #114 'could not get to treatment this evening'.

On January 28, 2015, Inspector #595 entered a resident dining room at 1710h. All four residents at one table, #054, #055, #056, #057, had been served their dinner. All four of these residents required total assistance from staff with eating. PSW staff #117 approached residents #055 and #056 and started to feed them. A few minutes later, the staff member went to feed resident #057, and returned back and forth to residents #055 and #056. PSW staff #117 then stood up and attempted to feed resident #054, who would not wake up at the table. (595)

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

Apr 30, 2015(A1)

O.Reg 79/10, s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Order / Ordre :

Ontario

Ministry of Health and Long-Term Care

Ministère 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

(A1)
The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that a resident s condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing, at least every eight hours, and at any other time when necessary based on the resident s condition or circumstances when a resident is being restrained by a physical device.

The plan shall include specified time frames for the development and implementation and identify staff member (s) responsible for the implementation as required under O.Reg. 79 10, s. 110. (2) 6

This plan shall be submitted in writing to Jennifer Lauricella, Long Term Care Homes Nursing Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564-3133. The plan must be submitted by March 27, 2015.

Grounds / Motifs :

1. Four previous Compliance Orders (CO) were issued under O.Reg 79/10, s.110 in January 2012 during inspection #2012_099188_0005, July 2012 during inspection #2012_099188_0027, April 2013 during inspection #2012_104196_0033 and August 2013 during inspection 2013_139163_0020.

The licensee has failed to ensure that the resident's condition is reassessed and the effectiveness of the restraining evaluated by a registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

On January 22, 2015, at 1518 hrs, Inspector #603 interviewed registered staff #125 who explained that staff do not reassess resident's condition and the restraint's effectiveness, at least every eight hours while a resident is restrained. The staff explained that this reassessment is only done on the quarterly evaluations. On January 27, 2015, at 1115 hrs, Inspector interviewed registered staff #126 who explained that the registered staff do not assess the resident's response to the restraint and the need for continued usage of restraint each shift. The staff also

explained that this is only completed on the quarterly evaluation.

On January 22, 2015, at 1535 hrs, Inspector #603 interviewed registered staff #119, who could not explain the home's expectation around residents' regular reassessment and documentation of restraints. The staff explained that the PSWs document on the Restraint Record that the restraint is being utilized according to the physician's order and the RPNs sign off on the MAR that the resident is restrained as per physician's order. The staff explained that any reassessment of restraint is only completed in PCC when the quarterly evaluation is completed.

Inspector #603 reviewed the Physical Restraint policy dated November 2012, which indicated under Evaluation: 1. At a minimum, the resident's response to the restraint and the need for continued use of the restraint must be evaluated each shift and documented either on the Restraint Record, or where e-documentation is in place. This is not being done.

While interviewing registered staff #125 and #126, both staff explained that they are not aware as to why they have to check off every morning at 0700 hrs about the tilted chair as a restraint. They both thought that it was a reminder that the resident has a tilted wheelchair as a restraint.

Inspector #603 reviewed the resident's care plan on Physical Restraint: Tilt Wheelchair and it did not indicate regular evaluations, however it indicated the need for reassessment in 3 months (January 1, 2015). [s. 110. (2) 6.] (603)

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

Mar 31, 2015

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 005

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

Linked to Existing Order / Lien vers ordre existant: 2014_281542_0024, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

Ministère 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

Grounds / Motifs :

1. A previous Compliance Order was issued under LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) in December 2014 during inspection #2014_281542_0024.

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

On January 22, 2015, Inspector # 542 reviewed Critical Incident (CI) that was submitted to the Director March 2014. The CI was submitted in regards to staff to resident abuse. The CI indicated that resident #039 reported that Personal Support Worker #136 had been abusive towards them and wanted to steal their belongings. The licensee completed an investigation which further identified that resident #039 did not want this PSW staff to care for them anymore and PSW staff #136 was terminated. On Janurary 28, 2015, Inspector #542 reviewed PSW staff #136's employee file, the letter of termination indicated that staff member's actions were not in keeping with the resident's wishes and were a breach of the residents rights to be free from abuse. (542)

2. Inspector # 542 reviewed a Critical Incident (CI) that was submitted. The CI indicated that registered staff #124 was overheard threatening resident #035 if they didn't stop being rude. Inspector reviewed the employee's personal file which included two separate incidents where registered staff #124 was abusive towards resident #035. On both occasions the registered staff was instructed to read their professional standards and further incidents of abuse towards residents could result in further discipline.
The licensee discharged registered staff #124 from employment at the home during the investigation of the Critical Incident that was submitted to the Director. (542)

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

Mar 31, 2015

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

Ministère 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

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

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

Ministère 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

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
Toronto ON M5S 2B1
Télécopieur : 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
Toronto ON M5S 2B1
Télécopieur : 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 31 day of March 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JENNIFER LAURICELLA - (A1)

Service Area Office /
Bureau régional de services : Sudbury