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

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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
Dec 30, 2015;	2015_289550_0025 (A1)	O-002664-15	Resident Quality Inspection

Licensee/Titulaire de permis

GENESIS GARDENS INC
438 PRESLAND ROAD OTTAWA ON K1K 2B5

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

FOYER ST-VIATEUR NURSING HOME
1003 Limoges Road South Limoges ON K0A 2M0

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

JOANNE HENRIE (550) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The Compliance Order report was amended to change the dates a progress report is required to February 25, 2016 and April 21, 2016.

Issued on this 30 day of December 2015 (A1)

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

Original report signed by the inspector.

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JOANNE HENRIE (550) - (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): October 26, 27, 28, 29, 30, November 2, 3, 4, 5, and 6, 2015 and off site inspection was also done on November 10 and 12, 2015.

This inspection also included two complaints under OSAO Log O-001506-15 and O-001961-15, four critical incidents under OASA Log O-002742-15, O-001553-15, O-001999-15 and O-002532-15 and six follow-up to Compliance Orders under OSAO Log O-002834-15, O-001489-15, O-1490-15, O-001492-15 and O-001934-15.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Activity Director, the Food Service Supervisor (FSS), the RAI/MDS-Educator-Infection Control Nurse, the Maintenance and Housekeeper Supervisor, Registered Nurses, Registered Practical Nurses, Personal Support Workers (PSW), the President of the Resident Council, the President of the Family Council, family and residents.

In addition, the inspectors reviewed resident health care records, policies related to the medication administration, the infection control and the restraints, resident council minutes and family council minutes. Inspectors observed resident care and services, staff and resident interaction, and

meal services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

- **22 WN(s)**
- **10 VPC(s)**
- **4 CO(s)**
- **3 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 19. (1)	CO #005	2014_289550_0025	126
O.Reg 79/10 s. 20. (1)	CO #001	2015_289550_0019	550
LTCHA, 2007 s. 6. (1)	CO #001	2015_289550_0005	550

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee failed to ensure that the quality improvement and utilization review system under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its policies, procedures and protocols to identify initiatives for review.
2. The system must be ongoing
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Inspector #545 reviewed the home's Continuous Quality Improvement (CQI) manual. Upon review of the "Terms of Reference", it was indicated that the "committee" would

develop an annual work plan to simplify and streamline quality improvement, activities, monitoring and reporting of care, such as to:
- Identify, categorize and prioritize issues for improvement
- Seek out, monitor and respond to quality and safety issues
- Identify emerging knowledge and evidence, trends or innovations
- Assess quality assurance, monitoring and auditing.

The Terms of Reference also indicated the committee would strive to meet weekly, and that a meeting must be held every two weeks, as well as reporting regularly to Residents and Families on priorities, the targets identified and the plans to achieve them.

During an interview with the Administrator, he indicated to Inspector #545 that the home was still in the process of developing their quality improvement utilization review system. The Administrator indicated that the policies, procedures and protocols had not yet been developed.

The Administrator indicated that the CQI Committee had not met since June 23, 2015, as evidenced by minutes provided to the Inspector.

The Administrator further indicated to the inspector that in 2015, the home focused on improving care plans, and that other priorities had not been completed as planned in the home's internal plan developed in November 2014. He further indicated that the home did not monitor, analyze, evaluate and improve the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home, as identified in their plan, other than the residents' care plans.

Because a quality improvement and utilization review system is not fully implemented, functional and ongoing in the home, the licensee has issues with their infection control program and their minimizing of restraint policy which poses a high risk to their residents. There are also recurring non compliance in regards to dining and snack service, care plans, accommodation services, reporting certain matters to the director, restraining by physical devices, training of staff, the satisfaction survey, bed rails, reporting of critical incidents and safe storage of drugs.

Non-compliance under LTCHA, c. 8, s. 84 was previously issued as a written notification on May 31, 2012, and as a compliance order, inspection #2014_289550_0012 on November 7, 2014 with a compliance date of March 31, 2015. [s. 228.]

2. . [s. 228.]

Additional Required Actions:

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

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program; O. Reg. 79/10, s. 229 (2).
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).
(c) that the local medical officer of health is invited to the meetings; O. Reg. 79/10, s. 229 (2).
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and

implementation of the infection control program;
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
(c) that the local medical officer of health is invited to the meetings;
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Inspector #550 reviewed the Infection Control program manual that was provided by the ADOC and noted the manual was signed as having been revised by the Infection Control nurse and was dated September 2015. Upon a review of the said manual, Inspector #550 observed that many of the home's policies were old and not updated to reflect current best practices.

Inspector #550 interviewed the Infection Control nurse. She indicated she did not participate in the evaluation and the update of the Infection Control program as this was assigned to the Director of Care (DOC) and the previous ADOC. She indicated to inspector she reviewed and signed the Infection Control policies in the manual in September 2015 because the home was scheduled to have their Accreditation and this needed to be completed for Accreditation purposes. She further indicated she did not use the best practices from PIDAC when she reviewed the policies.

During an interview the DOC indicated she was involved in the revision and update of the Infection Control program with the former ADOC but from a distance. The DOC indicated that she is unsure of what was completed and what still needs to be done and that the former ADOC has left the home since August 2015. She indicated they referred to the best practices document from Provincial Infectious Disease Advisory Committee (PIDAC) and that she has this document for reference.
Inspector #550 observed that resident #025 and #043 both had a contact to contact precaution sign posted at their bedroom entrance next to the door. No hamper was observed in either resident's bedroom for staff to dispose the contaminated gowns. There was no isolation cart containing the proper personal equipment available to staff to wear when caring for those two residents inside or outside of the resident's bedroom. Inspector observed resident #025 had a few isolation gowns in the last drawer of the bedside dresser but resident #043 had none. A review of both

residents' health records indicated residents #025 was diagnosed with a specific infectious disease since his/her admission on a specific date in July 2015 and resident #043 was also diagnosed with another specific infectious disease on a specific date in September 2015. Both residents require special precautions in place due to these infectious diseases.
During an interview, PSW staff #S127 indicated to Inspector #550 there usually is a hamper in resident #025 and #043's bathroom but there were none at the time of the interview and she had to walk outside of the resident's rooms to the hamper in the hallway to dispose of the contaminated linen in the hamper that is kept in the hallway. They do not have any personal protective equipment (PPE) in both residents' rooms except for the isolation gown in resident #025's bedside dresser. She indicated she had to get all of the PPE in the isolation cart that is kept in the tub and shower room.

PSW #S126 indicated to Inspector #550 she was the PSW assigned to resident #025 and #043 and that when she provides direct care for these two residents she has to wear gloves. Inspector #550 showed PSW# S126 that the contact to contact precaution sign at the entrance of the bedroom door for resident #025 and #043 indicated hand washing, gloves, gown and dedicated personal equipment. When inspector pointed out that on the contact precaution sign for resident #025 both the gloves and gown were circled, PSW #S126 indicated that she forgot but she also needs to wear a gown with the gloves when providing direct care to this resident but that no other precautions are required. She further indicated that because there is nothing circled on the contact to contact precaution sign at resident #043's bedroom door entrance, she only has to wear gloves when providing care to this resident, no other precautions are required.

RPN #S125 indicated to Inspector #550 during an interview that when staff is caring for resident #025 they have to be careful and when the resident has a cold, they have to wear a mask and goggles. During any other time they have to perform hand washing only. When staffs are caring for resident #043, they have to use universal precautions and wear gloves when providing pericare. She indicated the PSWs have to wear a gown when they are providing direct care to the resident and the nurse also has to wear a gown and gloves when she is changing the resident's dressing and perform hand washing after.

RPN staff #S125 indicated to Inspector #550 they do not have dedicated equipment as it is indicated on the contact to contact precaution sign. She indicated when she has to share a piece of equipment such as a sphygmomanometer with other residents in the home; she will clean this equipment with alcohol swabs after using it with this

infected resident.

Inspector #550 reviewed the actual plan for both resident and observed there was a separate sheet for both residents in their health records as part of the written care plan for theses residents and observed it was revised and printed on November 3, 2015.
Inspector interviewed the Infection control nurse who indicated that after our discussion the day before, she looked in these two resident's written plan of care and observed their plan of care had not been revised and updated to reflect their infectious disease. She then updated resident #025 and #043's written plan of care to reflect their infectious disease and printed them for staff.

During a revision of resident #025's plan of care Inspector #550 observed the interventions listed indicated:
-a specific infectious disease precautions in effect
-Resident #025 has had 2 negative results
-Resident #025 must have 3 negative cultures taken at least 1 week apart.

During an interview, the Infection Control nurse indicated to Inspector #550 that the home's policy for MRSA which is the policy staff should refer to guide them for the "MRSA precautions in effect" is kept in the infection control manual located in the infection control nurse. The infection control manual is kept in the Infection Control nurse's locked office. When she is not working, the PSW's do not have access to her office.

The ADOC indicated to Inspector #550 only the managers have access to the office of the Infection Control nurse where the Infection Control policies manual is located. [s. 229. (2)]

Additional Required Actions:

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

DR # 003 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the equipment is kept clean and sanitary.

During the resident observation Inspectors #550, #545 and #592 observed several resident's ambulation equipment to be unclean on October 27, 28, 29 and 30, 2015 as follows:

resident #022's wheelchair seat cushion was soiled with streaks of liquids,
resident #003's wheelchair both arm rests were covered with dried up debris and whitish film, the seat belt was covered with white stains and dried up food and the wheelchair frame was covered with dust and some dried up food,
resident #006's seat belt from the loaned wheelchair was covered with dried debris, and
resident #009's wheelchair frame was dusty, there were some debris stuck to the frame around the brake system and on the right foot rest.

The ADOC indicated to Inspector #550 during an interview that the PSWs are required to clean the residents' ambulation equipment as per the schedule posted in the tub and shower rooms and sign the sheet when they have completed the task. She further indicated if the sheet is not signed, it means the task was not done. If a resident's ambulation equipment becomes dirty between the scheduled cleaning routine, the home's expectation is that the PSW caring for the resident will do a quick

clean up of the chair and will then leave a note in the report book for the PSW working the 1:00PM to 9:00PM shift to do a thorough cleaning.

Inspector #550 and the ADOC observed that all the resident's ambulation equipment as noted above remained unclean.

Inspector #550 reviewed the report book from October 25 to 30, 2015 and observed there was no documentation regarding cleaning of mobility equipment for any of those residents.

Inspector #550 and the ADOC reviewed the sheets posted in the tub and shower rooms that the PSWs have to sign after they have cleaned a resident's ambulation equipment for the month of October, 2015. It was observed that there was no documentation for resident #022 and that this resident is not on the cleaning schedule. The ADOC indicated this resident has been using a wheelchair for only 5 days but the PSW's should have cleaned the seat cushion as soon as they noticed it was unclean. There was no documentation for resident #003 and #009. It was documented resident #006's wheelchair was cleaned weekly and the last time was 2 days ago. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On October 28th, 2015, Inspector #592 observed in a shared bathroom between two (2) specific rooms a grabbing bar on each side of the toilet. When inspector #592 touched the grabbing bars, both of them were wobbling and not fix to the ground, posing a risk to the safety of the residents who are using the grabbing bars.

Upon showing the grabbing bars on each side of the toilet to PSW #121, she told inspector #592 that both grabbing bars are being used for three of the four residents who are sharing the bathroom to provide them stability and assistance when they are getting up from the toilet.

On November 02, 2015, upon showing the grabbing bars to the environmental manager, he indicated that the grabbing bars were safe for residents but that they were maybe loose and that he would try to purchase new ones. He further indicated that Resident #022 was not using the toilet alone, therefore lowering the risk of any injuries.

Upon a review of resident #022 health care records, it is indicated that resident #022 has poor weight bearing with unsteady gait. It is further noted in the progress notes that on November 02, 2015, Resident #022 went to the bathroom on his/her own a few times and was at risk for falls.

On November 02, 2015, upon showing the grabbing bars to the ADOC, she told inspector #592 that the grabbing bars were unsafe and were putting residents at risk and should be replaced with safer ones. [s. 15. (2) (c)]

3. From October 26 to November 6, 2015 the following areas of disrepair were observed and noted
-walls in bathroom in room 102 were damaged
-caulking around the toilet in room 102 was missing
-floor tiles around the toilet in bathroom in room 107 were stained
-floor tiles under the baseboard heaters in the small dining room were broken where the sub floor raised up exposing the cement sub-floor where dust and debris have accumulated
-well-worn varnish on the wooden handrails in the hallways exposing the wood grain
-floor tiles under the baseboard heaters in room 120 were broken where the sub floor raised up exposing the cement sub-floor where dust and debris have accumulated
-there were 2 vinyl lazy boy chairs in the television lounge with ripped vinyl exposing the material and foam underneath
-baseboard heaters in both dining rooms were dented with paint scuffed in several areas and rusted.
-resident #005 and #008: Inspector #545 observed the sink drain in the resident's shared washroom was rusted
-resident #010: Inspector #545 observed the sink drain in the resident's washroom was rusted. Inspector #592 observed the call bell button to be removed from its socket, exposing the inside mechanism of the call button.

Inspector #550 toured the home with the Administrator and it was observed that many of the issues identified in September 2014 were the same issues identified above such as:
-walls in bathroom in room 102 were damaged
-caulking around the toilet in room 102 was missing
-floor tiles around the toilet in bathroom in room 107 were stained
-floor tiles under the baseboard heaters in the small dining room were broken where the sub floor raised up exposing the cement sub-floor where dust and debris have accumulated

-well-worn varnish on the wooden handrails in the hallways exposing the wood grain
-floor tiles under the baseboard heaters in room 120 were broken where the sub floor raised up exposing the cement sub-floor where dust and debris have accumulated
-there were 2 vinyl lazy boy chairs in the television lounge with ripped vinyl exposing the material and foam underneath
-baseboard heaters in both dining rooms were dented with paint scuffed in several areas and rusted.

The Administrator was disappointed to see that some of the identified areas of disrepair last year were not addressed. He indicated to the inspector he had given the report to his maintenance person thinking he would repair every area identified in the report. He further indicated the maintenance supervisor was on a leave for 2 months but that he should have informed the Administrator what was not done.

The Administrator indicated to the inspector he was not aware of any of the areas in disrepair identified during this RQI. He indicated that when staff observes an area in need of repair they will write a note in the maintenance book for the maintenance person to address and repair. He indicated he conducted a high level audit of the home on a monthly basis to identify some areas in need of repair but that sometimes he does not see all the areas in need of repair as he's in the home on a daily basis. Inspector #592 reviewed the maintenance log book from November 2014 to this day and observed that the rusted sink drain in bathroom #107 and #102 and the defective call bell in room #102-4 were not reported for repair.

The Administrator showed inspector #550 a schedule for routine, preventative and remedial maintenance which he identified as a schedules for routine, preventative and remedial maintenance. This was a chart with tasks to be done on a daily, weekly, monthly and quarterly basis and once the tasks were completed, the maintenance person checked the corresponding box to indicate it was done.

The Administrator further indicated he did not develop and establish any procedures for the routine and remedial maintenance to ensure ongoing maintenance for home repair and he did not think of asking for an extension to the compliance date.

Non-compliance was previously issued under LTCHA, S.O. 2007 as a voluntary plan of correction on May
31st, 2012 and as a compliance order on November 7, 2014. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. Policy to minimize restraining of residents
The licensee failed to ensure that the home's written policy under section 29 of the Act deals with,
• restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others;
• types of physical devices permitted to be used;
• how consent to the use PASDs as set out in section 33 of the Act is to be obtained and documented
• alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach
• how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation.

The Long Term Act indicates that a physical restraint includes all devices used by the home that restrict freedom of movement or normal access to one's body. A resident

may be restrained by a physical device if the restraining of the resident is included in the resident's plan of care. The use of a physical device from which a resident is both physically and cognitively able to release themselves is not a restraining of the resident. The Resident Assessment Instrument (RAI) defines a physical restraint as: "as any manual method, or any physical or mechanical device, material, or equipment, that is attached or adjacent to the person's body, that the person cannot remove easily, and that does, or has the potential to restrict the resident's freedom of movement or normal access to his or her body.

The Inspector reviewed the Home's policy: Least Restraints Policy Resident Safeguard, with a revision date of June 2013 as indicated by the Assistant Director of Care (ADOC).

During an interview with the DOC, she indicated that the home's Least Restraints Policy Safeguard had been reviewed in June 2013 based on the Ministry of Health and Long Term Care Standards dated November 2004 (Document #0809-01), which do not include all requirements as per the Long Term Care Act, 2007 and regulations.

Inspector #545 determined that the policy did not contain all the requirements under sections 109 through 113 of the Ontario Regulations 79/10 (Policy to Minimize Restraining of Residents).

The Policy did not indicate:
(c) Restraining under the common law duty pursuant to subsection 36 (1)
of the Act when immediate action is necessary to prevent serious bodily harm to the person or
others;
(d) Types of physical devices permitted to be used;
(e) How consent to the use of PASDs as
set out in section 33 of the Act is to be obtained and documented;
(f) Alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and
(g) How the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation.

Mandatory Annual Training and Training at Orientation in the area of the home's policy to minimize the restraining of residents
During resident observations conducted as part of Stage 1 of the Resident Quality

Inspection (RQI), several residents were observed in wheelchairs with one, two and three restraints. As a result of these observations LTCH Inspector #545 interviewed staff, about the training they received, specifically related to restraints and personal assistive services devices (PASDs), reviewed residents' health records and the home's least restraint policy.

Restorative Care/PSW #114 indicated that she believed that restraint training was provided by the home's occupational therapist that visits the home monthly. She was unable to recall the date when the training was last provided.

PSW #110 and PSW #107 who have been employees in the home for more than 20 years indicated that they had not received training on restraints and PASDs. PSW #107 thought that a physiotherapist had provided a session approximately five years ago. RN#101, who has worked in the home for three years indicated that she did not receive training on restraints and PASDs, not upon hire and not annually.

In an interview with the Education Lead, she indicated that training on restraints and PASDs had not been provided to direct care staff, including registered staff for at least four years, added that she was not aware that this training was required annually. She further indicated that the home's orientation program did not include training on restraints and/or PASDs.

During an interview with the DOC on November 3, 2015 she indicated that the home did not provide training to staff who apply physical devices and/or PASDs or who monitor residents restrained by physical devices and/or PASDs, training in the application, use and potential dangers of these physical devices, upon hire and annually as per legislation.
Restrained by physical device not included in resident #029's plan of care
Resident #029 was admitted to the home on a specific date in the winter of 2011 with several medical conditions including stroke and depression and had an amputation of a specific body part and seizure disorder. According to the most recent assessment dated October 7, 2015, the resident was dependent for all activities of daily living, was wheelchair bound and wheeled by others, and had no trunk restraints or was not in any chairs preventing rising.

Upon review of the most recent plan of care (dated a specific date in August 2015), it was indicated that resident #029 had a front fastening seat belt when in his/her wheelchair. The note also indicated that the front fastened seat belt was not used as a restraint.

On October 28, 29 and November 2, 2015 the inspector observed resident #029 in a tilt wheelchair with a 4-point front fastened seat belt as well. When asked if could release the front fastened seat belt, the resident was physically unable to, it is to be noted that the resident's specified limb was paralyzed and resting on a quarter padded resting device.

PSW #122 indicated that the resident had a front seat belt when in his/her wheelchair, and she did not think the resident was able to remove it anymore, that it was applied to prevent him/her from falling. The PSW indicated that that she did not believe the Resident was able to remove the front fastening seat belt.

RPN #125 indicated that the resident was used for safety, prevention of falls and positioning. Indicated that the resident use to try to get out of the wheelchair but in the last year, did not make any attempts. The RPN indicated that that she did not believe the resident was able to remove the front fastening seat belt.

During an interview with the ADOC, she indicated that the most recent plan of care did not provide clear directions to staff related to a physical restraint such as a front fastening seat belt, used daily for resident #029.

Resident #010's physical device was not applied in accordance with instructions specified by the physician
Resident #010 was admitted with several medical conditions including Alzheimer's Disease with severe cognitive impairment and a specific eye disease. According to the most recent assessment the resident was assessed as not having a trunk restraint.

During observations on October 27, 29 and 30, 2015, Inspector #545 observed resident #010 in a tilt wheelchair, with a front closure seat belt including a padded table tray. When asked, the resident was physically and cognitively unable to remove the table tray and release front closure seat belt.

Upon review of the resident's health record, it was documented in the quarterly medication review dated a specific date in September 2015 by the physician that the following safety devices were prescribed:
- Lap belt to wheelchair (front fastening) PRN (as needed) for safety and provide rest period
- Table tray to wheelchair or rock chair PRN (as needed) for safety and provide rest period

In a review of the Restrictive Devices: Monitoring/Repositioning Record for the month of October 2015, it was documented that resident #005 had a front fastening lap belt and a table tray to his/her wheelchair from 0700 to 2000 or 2100 each day. There was no indication that the restraints were applied as per physician's order such as application as needed and provision of rest period.

During an interview PSW/Restorative Care #114, she indicated that the resident had a front fastening seat belt and a padded table tray at all times, not as needed as per the doctor's orders. She indicated that the resident did not receive rest periods, other than on the 8 specified days in October 2015 that he was walked by two staff.

PSW #103 indicated on October 30, 2015 that the resident had a front fastening seat belt and a table tray to prevent falls. The PSW indicated that the resident had these restraints to prevent falls and for his/her safety, added that she was not aware of recent falls or if the resident made attempts to get out of his/her wheelchair. She further indicated that the front fastening seat belt and table tray were applied in the morning when resident was transferred to the wheelchair for breakfast. She indicated that the resident did not rest after breakfast or after lunch, and that he/she watched TV in the lounge and/or his/her room.

The ADOC indicated that resident #010 was not provided rest periods from front fastening seat belt and table tray on day and evening shifts. She further indicated that the physical devices were not applied in accordance with instructions specified by the physician.

No physician order or consent by SDM for restraining by physical device for resident #005.

On October 28, 29 and 30, 2015 Inspector #545 observed resident #005 in a tilt wheelchair with a front fastened seat belt as well as a clear plastic tray table fastened at the back of the wheelchair. On 2 occasions the resident was asleep in front of the TV in the lounge and on another occasion, the resident was asleep in his/her bedroom by the bed.

In a review of the resident’s health record, orders by a physician or registered nurse in the extended class and consent by the resident’s Substitute Decision Maker (SDM) for a tray table with rear fasten was not found.

The most recent Plan of Care dated a specific date in October 2015 indicated that the resident used a tilt wheelchair, a tray table, foot rests and front fastening belt. There was no indication that the tray table was fastened at the back of the wheelchair.

During an interview with PSWs #116 and #103, they indicated that the resident had a tray table with a rear fasten to the back of the chair. Both PSW indicated that the seat belt and the tray table were used for the resident's safety and to prevent falls, as well as to place the drinks at snack time and to rest his/her arms. PSW #116 indicated that she thought that the resident sometimes put his/her hands under the tray and pushed it out of the way.

The ADOC indicated on October 30, 2015 that staff was applying on a daily basis a physical device, such as a tray table with rear fasten which resident #005 was unable to release. The DOC further indicated that the restraint by physical device had not been ordered or approved by a physician or registered nurse in the extended class and consent by the SDM had not been received, as per legislation.
resident #005 and #029's condition was not reassessed and the effectiveness of the restraining not evaluated, in accordance with the requirements provided for in the regulations.

On October 28, 29 and 30, 2015 Inspector #545 observed resident #005 in a tilt wheelchair with a front fastened seat belt as well as a clear plastic tray table fastened at the back of the wheelchair. On 2 occasions the resident was asleep in front of the TV in the lounge and on another occasion, the resident was asleep in his/her bedroom by the bed.

In a review of the quarterly physician orders, it was documented that the following restraints were prescribed since admission on a specific date in the fall of 2012:
-Safety: Lap belt (front fastening) to wheelchair for safety & optimal positioning
-Safety devices: 2 bedside rails up for safety

The most recent Plan of Care dated a specific date in October 2015 indicated that the resident used a tilt wheelchair, a tray table, foot rests and front fastening belt. It was also documented that the resident was at medium risk for falls.

A consent signed by the resident's family member on a specific date in the fall of 2012 indicated that a safety lap belt (front fastening) and two beside rails would be used to increase the resident's safety due to a loss of muscle tone, decrease mobility, incontinence, constipation and altered circulation. Benefits were documented as:

reduction in risk of falls and provision of sense of security. No other assessment of methods of restraining was found in the resident's health record.

During an interview with the Restorative Care staff #S114 she indicated that the physiotherapist should have reassessed the resident's restraints to address the risk, however she was unable to provide evidence of this. She further indicated that the resident was admitted with all three restraint methods: tilt, front fastened seat belt and rear fastened tray table.

The ADOC indicated during an interview on October 30, 2015 that resident #005's methods of restraining had not been re-evaluated since the resident's admission in 2012 to address the risk. The ADOC further indicated that she was not aware of any recent falls or attempts to get out of the wheelchair for resident #005 and that in his/her present condition, resident #005 probably no longer required some of these restraints.

On October 28, 29 and November 2, 2015 the Inspector observed resident #029 in a tilt wheelchair with a 4-point front fastened seat belt as well. When asked if could release the front fastened seat belt, the resident was physically unable to, it is to be noted that the resident has a paralysis to a specific limb and it was resting on a quarter padded device.
In a review of the quarterly physician orders (September 2015), it was documented that the following restraints were prescribed, since March 2015:
-Safety: Lap belt (front fastening) to wheelchair for safety & optimal positioning
-Safety devices: 2 bedside rails up for safety

The most recent Plan of Care dated a specific date in September 2015 indicated that the resident had a front fastening seat belt when in wheelchair for optimal positioning; not used as a restraint. There was no mentioning of the use of a tilt wheelchair, preventing the resident from rising.

A consent signed by the resident's family member on a specific date in December 2011 indicated that a 4-point belt would be used to improve posture support and comfort and reduce risk for falls and injuries. There was no documentation indicating that the resident's condition was reassessed and the effectiveness of the restraining re-evaluated since his/her admission in 2011.

PSW #122 indicated that resident #029 had a front fastened seat belt and was in a tilt wheelchair, she further indicated that the resident was unable to release the seat belt

and she had never seen him/her making attempts in getting out of the wheelchair.

The ADOC indicated during an interview on November 2, 2015 that resident #029's methods of restraining had not been re-evaluated since his/her admission in 2011 to address the risk and/or effectiveness of the restraining devices. The ADOC further indicated that she was not aware of any recent falls or attempts to get out of his/her wheelchair and that in this present condition, resident #029 may require a re-evaluation the restraining by physical devices.

No alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach for residents #005, #010 and #029. These residents were observed restrained by physical devices between October 26 and November 6, 2015.

A review of these residents' health record was conducted and documentation of alternatives to the use of physical devices, including how these alternatives were planned, developed and implemented, using an interdisciplinary approach, was not found.

Resident #005's Physical and/or Chemical Restraint Consent Form indicated on a specific date in November 2012 that options discussed were two bed rails raised for resident's safety and a front fastened seat belt when in wheelchair for safety and optimal position.

Resident #010 Physical and/or Chemical Restraint Consent Form indicated on a specific date in January 2014 that options discussed were front seat belt when in wheelchair for safety and rest as needed and table tray when in wheelchair or in rocking chair for safety and rest as needed.

Resident #029 Physical and/or Chemical Restraint Consent Form indicated on a specific date in December 2011 that options discussed were a 4-point seat belt and two full bed rails be used as physical restraints.

The DOC confirmed that alternatives to the use of physical devices, including how these alternatives were planned, developed and implemented, using an interdisciplinary approach, was not done for the above three residents.

It is noted that this area of non-compliance related to Minimizing of Restraints was previously issued as Voluntary Plan of Correction (VPC) during the RQI 2014. [s. 29.

(1)]

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On October 30th, 2015, several beds were observed with immovable/non-adjustable bed rails in the upright position.

The following is a summary of the information gathered:

-17 immovable/non-adjustable bed rails were observed on a total of 57 beds.

-bed in room #126-4 was observed with one immovable/non-adjustable bed rail to the left side of the mattress and secured in place by a metal bracket located on the upper bed frame to hold the mattress in place.

-Bed in room #109 observed with one immovable/non-adjustable bed rail on the right side of the mattress.

-Bed in room #120-4 observed with one immovable/non-adjustable bed rail on the right side of the mattress and one full bed rail on the upright position to the left side of the mattress.
In an interview with Resident #033, he/she told inspector #592 that both rails were used to avoid the resident from falling on the floor.

-Bed in room #126-1 observed with one immovable/non-adjustable bed rail on the left side of the mattress and one full bed rail in the upright position to the right side of the bed.

-Bed in room #128-2 observed with one immovable/non-adjustable bed rail on the right side of the mattress and secured in place by a metal bracket located on the upper bed frame to hold the mattress in place. One full bed rail was observed on the right side of the mattress in the upright position.

-Bed in room #127-4 observed with one immovable/non-adjustable bed rail on the right side of the mattress.

-Bed in room #131-1 observed with one immovable/non-adjustable bed rail on the right side of the mattress.

-Bed in room #134-1 observed with one immovable/non-adjustable bed rail on the left side of the mattress and one full bed rail in the upright position to the right side of the bed.

-Bed in room #111-4 observed with one immovable/non-adjustable bed rail on the left side of the mattress and secured in place by a metal bracket located on the upper bed frame to hold the mattress in place. One full bed rail was observed on the right side of the mattress in the upright position.

-Bed in room #108-2 observed with one immovable/non-adjustable bed rail on the right side of the mattress and secured in place by a metal bracket located on the upper bed frame to hold the mattress in place. One full bed rail was observed on the right side of the mattress in the upright position.

-Bed in room #108-4 observed with one immovable/non-adjustable bed rail on the right side of the mattress and secured in place by a metal bracket located on the upper bed frame to hold the mattress in place.

-Bed in room #106-2 observed with one immovable/non-adjustable bed rail on the right side of the mattress.

-Bed in room #103 observed with one immovable/non-adjustable bed rail on the right side of the mattress.

-Bed in room #101-2 observed with one immovable/non-adjustable bed rail on the left side of the mattress and one full side rail in the upright position.

-Bed in room #102-1 observed with one immovable/non-adjustable bed rail on the right side of the mattress and secured in place by a metal bracket located on the upper bed frame to hold the mattress in place. One full bed rail was observed on the left side of the mattress in the upright position.

-Bed in room #102-2 observed with one immovable/non-adjustable bed rail on the left side of the mattress.

-Bed in room # 109 observed with one immovable/non-adjustable bed rail on the right side of the mattress.

The "Adult Hospital Beds: Patient Entrapment Side Rail Latching Reliability, and Other Hazards",
Health Canada Guidance Document indicates the open space within the perimeter of the rail called zone 1, present a risk of head entrapment and recommended space is less than 4 ¾ inches.

On all the bed listed above, the zone 1 of each immovable/non-adjustable bed rail were measured to be 18 inches long x 15 inches wide, which is exceeding the requirements from Health Canada Guidance Document and posing a risk to residents.

In an interview with PSW #S107 and #S110, they both told Inspector #592 that the immovable/non-adjustable bed rails were called bed helpers and were being used by residents for assisting them to reposition in bed.

In an interview with the Administrator and the DOC, they both told inspector #592 that residents who are using side and immovable/non-adjustable bed rail were not assessed and that bed system were not evaluated in accordance with evidence-based practices as the home were not aware of this process. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that an evaluation in accordance with evidence-based practices is conducted on all beds used by residents in the home to minimize the risk of entrapment,, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any person who had a reasonable grounds to suspect abuse of a resident by a staff that resulted in risk of harm has occurred or may occurred , immediately report the suspicion and the information upon which it was based to the Director.

On a specific date in April 2015, resident #026 used the call bell and when PSW #S131 answered the call bell, the resident told the PSW that a staff member had yelled at him/her, was rude and was loud with him/her. PSW S#131 informed Registered Practical Nurse (RPN) S#132 about the complaint of resident #026.

Following that incident, that morning PSWs #S120, #S124, #S133 went to resident #026 who informed them that he/she was afraid and that someone threw something at him/her. In an interview with Inspector #126, held on November 3, 2015, PSWs #S120 and #S124 indicated that resident #026 pointed the finger at PSW #S110, saying "it's him/her". They indicated that resident #026 was afraid and was crying. They also indicated that they each wrote a letter which they slipped under the door of the former Assistant Director of Care (ADOC) to inform her of the incident. They indicated that they had not immediately notified the nurse on the unit because the staff that was potentially accused was related to RPN S#132. PSW #S124 indicated that she thought that PSW #S133 had notified the RPN #S132 of the incident. She indicated that the former ADOC was notified via text message but was unsure when.

Former ADOC, returned to the home on a specific date in April 2015 and informed the Director of Care of the incident who initiated the investigation. The Director was notified of this incident on a specific date in April 2015 by the former ADOC via the Critical Incident System (CIS). The DOC indicated she did not know the reason why the Director was notified 6 days after the licensee became aware of the suspected potential abuse. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all suspected incidents of abuse of a resident by anyone are immediately reported to the Director,, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team providing a resident's care is held within 6 weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision- maker, if any.

On October 28, 2015, upon a family interview, it was brought forward to Inspector #592 that the family of resident #011 did not recall when they were invited to participate at the annual care conference for the resident.

Upon a review of resident #011's health care records it was noted that the resident was admitted in the fall of 2013 and an Admission Assessment/Summary care conference was held in the winter of 2013. No other indication that another care conference had been held was found in the resident's chart.

Inspector #592 reviewed two more resident health care records.

Resident #014's health care records were reviewed and indicated that the last annual care conference for this resident was held on a specific date in August 2014.

Resident #016's health care records were reviewed and indicated that the last annual care conference was held on a specific date in August 2011.

Inspector #592 reviewed the home's policy titled Resident's Care Conference, implemented on January 1992 and reviewed on June 13, 2015 and the following was documented:

Under Procedures, tab 2:
The resident's Care Conference will be schedule in accordance with the Attending Physician's weekly visit in order to make it easier for him to attend.

Under who should attend:
Administrator, Director of care, Caregivers, Therapeutic Service, Attending physician, Dietary Supervisor, Pharmacist, Activity Director, the resident and his/her Family Member.

It was observed documented on resident #011's post admission care conference on a specific date in December 2013 that the DOC and the Activity Director participated in the care conference and that no other members of the interdisciplinary team had attended.

Upon review of resident #014's last annual care conference held in the summer of 2014 it was observed documented that the Physician and the Director of Care participated in the conference and that no other members of the interdisciplinary team had attended.

On October 30, 2015, in an interview with PSW #S113, she told Inspector #592 that she has been working in the home for 11 years and she is a full time employee. She indicated that PSWs are never invited to the resident's care conferences as it is the DOC who is in charge of this.

On October 30, 2015, in an interview with the ADOC, she indicated to Inspector #592 that the home's interdisciplinary team was composed of the Food Service Supervisor, the Physician, the Activity Director, Restorative Care, the Infection Control Nurse, the

DOC and the Maintenance person. She further told inspector that the DOC is the person performing the annual care conference with the presence of the Activity director, resident and family members, adding that the physician, restorative program, pharmacy members and the food service supervisor were not participating to the annual care conference unless it was requested by family members/residents.

In an interview with the DOC, she confirmed to Inspector #592 that an annual care conference was not held annually for all residents and their substitute decision maker as it was hard to reach them sometimes. She indicated to Inspector #592 that the only member who regularly attended the resident's annual care conference was the Director of activity. She further told the inspector that the other members of the interdisciplinary team were only invited upon the family's request and that it would be impossible for the home to meet their policy as it was impossible for her to coordinate a meeting where all the interdisciplinary team members would attend on the same day at the same time. [s. 27. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident receives a post admission care conference and an annual care conference thereafter that includes the participation of the interdisciplinary team, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During stage one of the Resident Quality Inspection (RQI), while conducting resident's observations, inspector #592 observed that resident #016 had food debris around his/her mouth and on his/her left hand. Inspector #592 also observed resident #026's finger nails were untrimmed and had a brown matter under them.

Upon review of the two residents' Daily Flow Sheets record, it was noted that resident #016 and #026 were to be provided two bath per week as per the bath list schedule provided by the home.

Upon review of resident #016 Daily Flow Sheet record, a bath was scheduled to be provided to this resident on October 02, 06, 09, 13, 16, 27 and 30th, 2015. Inspector #592 observed that there was no documentation that a bath, shower or bed bath was given.

Upon review of Resident #026 Daily Flow Sheet record, a bath was scheduled to be provided to this resident on October 09, 12 and 16th, 2015. Inspector #592 observed that there was no documentation that a bath, shower or bed bath was given.

In an interview PSW #S120 and #S124 told inspector #592 that they were the two regular PSWs assigned for baths on days shift and that they were responsible to document on the Daily Flow Sheets once the bath was provided to the residents. Both PSW's told inspector #592 that the bath includes the cleaning and trimming of the nails and washing of the hair. Both PSW's further told inspector #592 that if one of the scheduled PSW for the bath shift is missing, the other PSW scheduled for baths will bathed the independent residents and those requiring assistance of one staff as per the bath schedule for that day. They will not bathed the residents who require extensive assistance as they are working alone. They both told Inspector #592 that when a resident's bath or other alternative to a bath (shower or bed bath) cannot be provided as scheduled on a specific day, the bath is not rescheduled for another day.

In an interview with the DOC she indicated to Inspector #592 that it was impossible for the staff members to provider residents with a bath twice a week when the home was experiencing shortage of staff members. She further told inspector #592 that she was

not aware that Resident #026 was not provided with a bath twice a week as this resident was to be provided a bed bath by the primary caregiver and not by the assigned PSW for baths. [s. 33. (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 every resident in the home receives a bath or shower at least twice per week,, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Resident #001 was admitted to the home in the spring of 2015 with several medical conditions, such as congestive heart failure, angina, abnormal hernia and a compression fracture to a specific body part. According to the resident's most recent assessment, it was indicated that the resident had mild pain to a specific body part with daily administration of analgesics.

During an interview with resident #001 on October 27, 2015 the Resident indicated

that he/she had pain in two specific body parts. The resident indicated that he/she used a pain relief rub that he/she kept at bedside four to five times daily and that it was helpful in relieving the pain. The resident showed the inspector three different rub located in the night table.

On November 5, 2015, Resident #001 indicated to the inspector that the pain in two specific body parts was constant due to several falls he/she had in the past, describing the pain as 8 out of 10, horrible constant pain. The resident indicated that he/she was upset that a nurse had removed the creams from his/her night table, as he/she could no longer rub those two specific body parts to decrease the pain. The resident further indicated that he/she was an independent person and that he/she had no intention of complaining and calling for assistance, and that he/she wanted to continue to administer his/her own creams.

Upon review of the Resident's health record, it was documented that Resident #001 was prescribed two specific analgesics four times daily, and same medication and dosage as PRN (as required), but none were administered in the months of September, October and November 2015. In a progress note dated a specific date in October 2015, it was indicated that two anlagesic rubs, a natural medication and a antibiotic cream were removed from the Resident's bedside and placed in a Ziplock bag in the pharmacy for other residents' safety. There was no documentation regarding pain assessment and alternate intervention.

During an interview with the ADOC on November 5, 2015, she indicated that resident #001 was a very independent resident, that he/she never complained or called for assistance. She indicated that the resident was administered two different analgesics four times daily to manage pain. She indicated that she was aware that the resident was unhappy when his/her rubs were removed from his/her bedside and that she had sent a text to the doctor on November 2, 2015 to request that the rubs be prescribed, and that he responded he would assess the resident at his next visit. The RN indicated that the doctor's visit was scheduled for November 12, 2015. She further indicated that a pain assessment was not conducted when the rubs were removed from the Resident's bedside, that she had not documented the text communication with the doctor into the Resident's health record but would document a late entry in the progress notes to alert other nursing staff.

In a review of the most recent plan of care dated a specific date in October 2015, it was indicated that resident #001 was an independent person, that he/she had chronic pain related to a fall and compression fracture to a specific body part. Some of the

interventions included to consult the physician if the medication ordered was ineffective, to reassure and support the resident, to encourage the resident to use the call bell to request assistance.

RN #S135 indicated to the inspector on November 5, 2015 that Resident #001 had chronic pain and was administered two different analgesics four times daily, and that PRN medication were rarely administered. She indicated that it was unfortunate that the resident's rubs were confiscated from his/her bedside last week as this was a resident who insisted on remaining independent. The RN indicated that pain had not been assessed using a clinically appropriate assessment, however she would assess it immediately. She later returned and indicated to the inspector that she had spoken to the resident, and assessed his/her pain; added that the resident stated that he/she did not want more pills, he/she would like to have his/her rubs in order to self-apply to specific body parts. The RN indicated that the Resident accepted application of a specific rub by the RN and indicated that it was effective in providing pain relief. [s. 52. (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 Resident #001's pain is assessed and interventions are put in place to alleviate his/her pain,, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspector #545 reviewed the Residents' Council meeting minutes for five meetings between September 25, 2014 and September 2, 2015. Residents' concerns and recommendations were indicated at the meetings that occurred on December 18, 2014, June 4, 2015 and September 2, 2015:
-requesting music groups in the evening
-requesting to see two choices of meal and dessert as concerned that most of the time the name of the dish on the menu doesn't reflect what is being served
-requesting that two meal choices be different, for example do not offer an egg salad sandwich or omelet for lunch as too similar
-reporting that some residents have to wait for assistance to get to the bathroom and to get to the dining room for meals
-requesting hot/cold ham instead of baloney, gravy served on the side, less food in the plates, more spices/salt as food too bland

The September 2, 2015 minutes were hand-written and in the Residents' Council's Binder provided to the inspector by the Activity Director on November 4, 2015.

During an interview with the President of the Residents' Council she indicated that she did not believe that the licensee responded in writing within 10 days of receiving Resident's Council advice related to concerns or recommendations.

The Activity Director indicated to the Inspector on November 6, 2015, that she was assigned as assistant to the Residents' Council. She indicated that she was responsible in taking minutes, typing them and ensuring that the Administrator, DOC and Food Services Supervisor received copies, and then the posting of the minutes in the home. She indicated that when there were concerns regarding food, she reported it immediately to the Food Services Supervisor following the meeting. The Activity Director indicated that the licensee did not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

The Administrator indicated during an interview on November 6, 2015 that the licensee did not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations. [s. 57. (2)]

Additional Required Actions:

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

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

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 the seven-day and daily menus were communicated to the residents eating in the main dining room.

The home has two dining areas: the main lounge with five tables and the main dining room with eight tables.
On October 26, 2015, lunch service was observed and the following was noted:

In the main lounge, the regular week at a glance menu was posted on a bulletin board, and the lunch menu was written in marker on a white board. In the main dining room, the week at a glance and the lunch menu were not posted.
At 12:32, meal service began in the main dining room.

At 12:35, a resident at a specific table was told what the meal options were and was asked what he/she would like. At 12:38, the three residents seated at another table were told what the meal options were and were asked what they would like. The lunch menu was not communicated to any other resident in the dining room.

Of the thirty three residents who ate lunch in the main dining room, the menus were communicated to four residents.

On October 27, 2015, the menu was not communicated to resident #025 who eats in the main dining room. The resident was served the fish entrée at 12:42. The resident did not attempt to feed himslef/herself and was not provided with assistance or encouragement to eat. Approximately fifteen minutes later, a PSW asked the resident if he/she would like the spaghetti meal instead; however there was no spaghetti left. Resident #025 stated that he/she did not like fish. A dislike of fish is indicated in resident #025's nutritional care plan.

The beverage choices at lunch on October 26 and 27, 2015 were not communicated to the residents eating in the main dining room. Beverages were pre-poured and placed at each resident's assigned spot in the dining room before meal service began. The Food Services Supervisor indicated that it was the home's practice not to communicate the beverage choices to the residents as a kitchen staff member pre-poured and put the drinks out using a list with the resident's beverage preferences. [s. 73. (1) 1.]

2. The licensee has failed to ensure that residents were served their meal course by course.

The tables referenced below are according to the home's main dining room seating plan.

The following was noted during an observation of the lunch meal in the main dining room on October 26, 2015:
On October 26, 2015 at 12:43, a PSW who was assisting residents at table a specific table, left the table and provided desserts to the three residents who were eating at another table. The three residents at this table were eating their main course when the dessert was served. The PSW then served dessert to the residents at different table. At this different table, four residents were eating their main course, and one resident had not received his/her main course when the dessert was served. Dessert was then served to other residents at different tables, some of whom were still eating

their main courses.

The care plans of five residents (resident #019, resident #025, resident #042, resident #043 and resident #046) were reviewed, and there was no indication that the residents indicated or required to not be served course by course.

The Food Services Supervisor was interviewed and indicated that dessert should only be served after the main course had been completed and cleared away. [s. 73. (1) 8.]

3. The licensee has failed to ensure that residents were provided with personal assistance and encouragement to eat.

The tables referenced below are according to the home's main dining room seating plan.

On October 26, 2015, at approximately 12:35, resident #025 at a specific table and resident #046 at another table were served their main courses. Neither resident attempted to feed themselves. There was a staff member sitting at both of the tables assisting other residents. At 12:47, resident #046 had a full plate of macaroni and cheese, minced peas, and a slice of bread. He/she also had pineapple and applesauce. At 13:03, the resident pushed himself/herself away from the table. He/she had not eaten any of his/her main course or dessert. At 13:05, a staff member cleared his/her plate and the resident was shown out of the dining room at 13:08. In the thirty minutes that resident #047 had food in front of him/her, he/she was not provided with personal assistance and encouragement to eat, and he/she did not eat any of his/her main course or dessert.

According to resident #046's care plan, he/she was assessed as being at high nutritional risk due to low body weight, poor appetite and dysphagia, and required for staff to cue, remind or wake up for meals. His/her October weight was 18.7kg below his/her ideal weight range.

At 12:53, resident #025 had a full plate of macaroni and cheese, peas and a slice of bread. He/she also had dessert. At 13:03, a staff member pushed his/her full plate of food away and put the dessert in front of the resident. In the approximately thirty minutes that resident #025 had his/her main course in front of him/her, he/she was not provided with personal assistance and encouragement to eat, and he/she did not eat any of his/her main course.

On October 27, 2015, resident #025 was served his/her main course at 12:43. The resident did not attempt to feed himself/herself and had a full plate of fish, mashed potatoes and cauliflower. At 12:56, a staff member called the resident's name and asked if he/she would like the spaghetti instead, but there was none left. Resident #025 was not provided with personal assistance and encouragement to eat, and he/she did not eat any of his/her main course for a second day in a row.

According to resident #025's care plan, he/she was assessed as being at moderate nutritional risk due to fair appetite and constipation, and required supervision, and oversight, encouragement or cueing to eat. [s. 73. (1) 9.]

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

The tables referenced below are according to the home's main dining room seating plan.

On October 26, 2015, lunch service was observed in the main dining room and the following was noted:

The main dining room has eight tables. Only table #3 had four residents who were all observed to feed themselves.

At approximately 12:32, resident #015 at a specific table and resident #042, resident #043 and resident #044 at another table were served their main courses.

Resident #015, resident #042 and resident #043 did not attempt to feed themselves.

At 12:40, eight minutes after receiving his/her plate, a PSW sat and assisted resident #015 to eat. At 12:41, nine minutes after receiving his/her plate, a PSW sat and assisted resident #042 to eat his/her pureed macaroni and cheese and mixed vegetables. At 12:43, the PSW left a specific table to provide dessert to the residents at another table, and one minute later, another PSW sat and continued to assist the resident to eat. At 12:46, the staff member reheated resident #043's food, and fourteen minutes after he/she was served, assisted resident #043 to eat his/her meal. [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 the menus are communicated to the residents, residents are served course by course, they are provided with encouragement and assistance to eat and that residents who require assistance are only served when assistance can be provided,, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to document and make available to the Family Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

The President of the Family Council indicated to Inspector #545 during an interview on October 30, 2015 that the results of the satisfaction survey was not made available to the Family Council.

The Administrator indicated to the inspector on November 3, 2015 that the results of the 2014 satisfaction survey were, in his view non-favorable, therefore he did not make them available to the Family Council in order to seek the advice of the Council . [s. 85. (4) (a)]

2. The licensee has failed to document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

The President of the Residents' Council indicated during an interview on November 5, 2015 that the results of the satisfaction survey was not made available to the Residents' Council.

The Activity Director, assistant to the Residents' Council indicated that she had not been informed by the Administrator that the results of the Satisfaction Survey needed to be made available to the Resident Council, in order to seek the advice of the Council about the survey. She indicated that it had not been done in the last year.

The Administrator indicated to the Inspector that the results of the 2014 satisfaction survey were, in his view non-favorable, therefore he did not make them available to the Residents' Council in order to seek the advice of the Council . [s. 85. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the results from the satisfaction survey are communicated to the Residents' and Family council, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is immediately informed, in as much detail as is possible in the circumstances of an unplanned evacuation and an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

The ADOC informed the Director via CIATT on January 14, 2015 that the home was experiencing a respiratory outbreak since January 5, 2015. The ADOC indicated they were late reporting because they were having issues with the CIS reporting system and they were not sure to whom and where to call to report.

The DOC indicated she did not know why the outbreak was not reported sooner other than they were having issues with the CIS reporting system and they did not know where to call. [s. 107. (1)]

2. As per a Critical Incident Report # 2746-000018-15, the residents of the home were evacuated on September 5, 2015 because of the activation of the fire alarm system. A Critical Incident Report was submitted to the Director on September 9, 2015; four days later.

In an interview with the Director of Care, she indicated to inspector #592 that the home had experienced some technical difficulties with their access to the critical incident reporting system and confirm that she had not called the after-hours CIATT line to inform them of the unplanned evacuation.

Therefore the licensee did not immediately inform the Director of the unplanned evacuation of their residents as per legislative requirements. [s. 107. (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 critical incidents are communicated to the Director in the time prescribed by LTCH Act,S.O. 2007,, to be implemented voluntarily.

WN #14: 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 has failed to ensure that drugs are stored in an area or a medication cart, that is secure and locked.

On October 27, 2015, Inspector #545 observed in resident's #001 room 4 different types of cream, a natural product and a medication for digestion.

Resident #001 told Inspector #545 that he/she is taking all of these medications for specific needs and that he/she purchased them on his/her own. The resident further told inspector #545 that he/she was independent and applying each creams on his/her own.

On October 29, 2015, in an interview with the ADOC, she told inspector #592 that no residents were allowed to keep medications in their rooms as all the medications should be stored and locked in the medication cart or the medication room. The ADOC further indicated to Inspector #592 that she was not aware that these medications were in the resident's room. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that medications in the home including topical creams are kept secured and locked,, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs was fully respected and promoted.

On October 28, 2015 at 0950, Inspector #545 knocked at a door of a shared resident bedroom to meet with resident #007. Upon entrance in the room, the inspector observed resident #002 lying in bed with his/her body exposed while PSW #S103 and #S104 were changing the resident's brief and positioning him/her in bed. The privacy curtains, as well as the curtains of the windows (1st floor) in the four bed shared room were not drawn. Resident #007 and #008 were in the room at the time of the observation.

During an interview with PSW #S103, she indicated that it was the home's expectation, that privacy curtains be drawn during resident's care provision.

On October 28, 2015 at 1310, Inspector #545 knocked at the door of a shared resident bedroom to meet with resident #007. Upon entrance in the room, PSW #S105 was leaving the room. The inspector observed resident #007 with his/her pants down to his/her ankles, sitting on the toilet skin exposed from abdomen to the knees. One PSW was standing by his/her side, the resident's wheelchair was set in front of him/her and the door of the bathroom was wide open. Residents #002 and #008 were in the room at the time of the observation.

PSW #S103 indicated to the Inspector on October 29, 2015, that doors of resident's bathroom were not always closed by staff when assisting resident's with toileting, especially if a mechanical lift was used. She indicated that staff did not use a mechanical lift when transferring resident #007 to and from the wheelchair to toilet.

During an interview with resident #007, he/she indicated that he/she did not require his/her wheelchair in the bathroom and that he/she frequently asked the staff to close the door of the bathroom when he/she was using the toilet but that they did not do so often. [s. 3. (1) 8.]

2. On October 28, 2015, Inspector #592 knocked at the door of room #102 and was informed to come in. Upon entrance in the room, Inspector #592 observed PSW #S106 and #S107 providing care to a specific resident in a specific bed. The resident's legs were uncovered and the incontinent product was exposed. Resident in bed #1 and #2 were present in the room. One of the PSWs was observed pulling the privacy

curtain between two specific beds, leaving the privacy curtains open at the foot of the bed, still exposing the resident in this specific bed to the other residents in the room. After approximately one minute, one of the PSWs pulled the privacy curtain on one side of the bed but during the provision of the entire care, the curtains remained opened at the foot of the bed exposing resident in a specific bed.

On October 29, 2015, in an interview with PSW #S106, she indicated to Inspector #592, that during the provision of care to residents, she always closes the privacy curtains on each side of the bed and use a cotton sheet to cover the resident's body parts. Upon being made aware by Inspector #592 that the privacy curtains for resident in a specific bed in a specific room were not drawn during the provision of the care, she indicated that she had pulled the curtains back to see who was entering the room but forgot to pull them back. [s. 3. (1) 8.]

3. On October 27, 2015 at approximately 10:00, resident #037 was escorted to the washroom by a staff member and was assisted to the toilet. Inspector #551 was in the room with two of the resident's roommates. The door to the washroom and the door to the room were left ajar, and resident #037 was easily seen while seated on the toilet from inside the room.

PSW #S107 was interviewed and stated that while assisting residents with toileting in the washroom, staff were expected to provide the resident with privacy by closing the washroom door. [s. 3. (1) 8.]

WN #16: 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).

Findings/Faits saillants :

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

Resident #008 was diagnosed with several medical conditions such as aphasia, osteoporosis and Alzheimer's disease. According to the most recent assessment, it was documented that the resident has limitation in range of movement of both arms and hands with partial loss of voluntary movement of shoulder/elbow and wrist/fingers of one side, and that the resident is totally dependent for all activities of daily living.

Inspector #545 observed that two specific body part of resident #008 were contracted and there was an offensive odor coming from those two specific body parts. There was no splint observed.

Posted at the resident's bedside, were step by step instructions written by the occupational therapist that directed staff on how to apply a splint daily to a specific body part. The instructions also indicated to remove the splint 30 to 45 minutes at every meals, then to put it back on for brief period of time if the body part/brace was wet and to always wear the brace at night.

During an interview with PSW #S122, she indicated that resident #008 did not have the brace in place to a specific body part when she arrived that morning.

PSW #S123 indicated that the splint had not been applied for several months, that she usually cleaned the resident's specific body part with the No Rinse Tena Cream each morning during care.

RPN #S112 indicated that the splint to resident #008's specific body part should always be applied as per instructions. The DOC later indicated that staff were expected to clean the resident's specific body part during care and as needed, and to apply the splint as recommended by the occupational therapist. [s. 6. (7)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors that residents do not have access to must be kept closed and locked.

On October 26, 2015 at 09:30AM and October 29, 2015 at 11:25AM, Inspector #545 observed the door to storage room #153 unlocked and wide opened. Upon entrance into the storage room, the inspector observed shelves with food in jars, in can and in boxes. The inspector also observed a large white door with a bolt lock, and when turned, the door unlocked and the inspector was able to open the door that leads to the parking lot. A pink sign on the door indicated that the door should be closed and locked at all times. On both observations, there was no staff providing supervision of the opened door.

On October 26, 2016 at 09:30AM, Inspector #545 observed that the door to the mechanical room #152 was closed but unlocked. Upon entrance into the mechanical room, the inspector observed several piece of equipment and supplies that could pose a safety risk to residents such as electrical breakers, hot water tanks, wires and a metal sheet with sharp edges. A pink sign on the door indicated that the door should be closed and locked at all times. No staff was observed inside the room or providing supervision of the unlocked room.

On October 29, 2015, PSW #S103 indicated that doors to storage #153 and mechanical room #152 are non-residential areas and should be kept closed and locked at all times.

Cook #S102 indicated to the inspector that the door to the storage room #153 had been left opened as they were expecting a delivery of food items. She indicated that the door should be closed and locked at all times. [s. 9. (1) 1. i.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

Room #108 is occupied by four residents.

At bed #1, when the privacy curtain was extended, there was approximately a one foot gap between the end of the privacy curtain and the wall.

Bed #1 and bed #2's head boards are against the same wall, and the beds are separated by dressers which are pushed against the wall. At bed #2, a ceiling track intersects the ceiling. There was no privacy curtain extending from the wall to the ceiling track, a distance of approximately two and a half feet.

At bed #3, when the privacy curtain was extended, there was approximately a one foot gap between the end of the privacy curtain and the windowsill.

At bed #4, when the privacy curtain was extended, there was approximately a two foot gap between the end of the privacy curtain and the wall.

Room #111 is occupied by four residents.

At bed #1, when the privacy curtain was extended, there was approximately a two foot gap between the end of the privacy curtain and the wall.

At bed #2, when the privacy curtain was extended, there was approximately a two foot gap between the end of the privacy curtain and the windowsill.

Room #120 is occupied by four residents.

At bed #1, when the privacy curtain was extended, there was approximately a two foot gap between the end of the privacy curtain and the wall.

At bed #2, when the privacy curtain was extended, there was approximately a two foot gap between the end of the privacy curtain and the windowsill.

The Assistant Director of Care was interviewed and stated that the privacy curtain should provide full privacy to the resident. [s. 13.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

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

Resident #005 was observed by Inspector #545 on October 28, 2015 with red and swollen eyes, dried up eye lashes with yellowish crust and white matter in the bottom of the left eye. On November 2 and 3, 2015 yellow crust was observed in the left eye as well as redness & some swelling.

Upon review of the Resident's health record, it was noted that a specific medication was ordered as needed. In the month of October and November 2015, this medication was not administered.

PSW #S126 indicated that the resident often had crusty eyes, especially in the morning due to an eye condition, and that the nurse often administered a specific medication. She indicated that it was difficult to clean the Resident's eyes as he/she was "feisty", added that if the resident let her she would use a facecloth and water.

In an interview with RPN #S125, she indicated that the resident had long eyelashes that were inverted and caused frequent eye infections. She indicated that a specific medication was ordered PRN, but that it had not administered in the last month. She further indicated that it was the direct care staff to clean his/her eyes during care provision, added that she would clean the resident's eyes if observed it, but had not observed it today. [s. 32.]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is dressed appropriately in accordance with his preferences.

Resident #029 has resided at the home since 2011. At some point the resident had an amputation of a specific limb. The resident requires full assistance for all aspects of his/her care, including dressing.

Throughout the course of the inspection, it was noted that resident #029 did not wear proper clothing to his/her specific limbs and had a towel or blanket covering his/her specific body part.
PSWs #107 and #103 were interviewed and stated that resident #029 has not worn clothing on his/her specific body part since the amputation. PSW #107 stated that the resident was being aggressive during care so wearing clothing to his/her specific body part was discontinued. RN #115 stated that resident does not wear specific clothing to specific body parts for comfort and to reduce the possibility of aggression.

Resident #029's care plan was reviewed, and there was no direction for staff to follow with regards to the resident not wearing a specific type of clothing to a specific body part. [s. 40.]

WN #21: 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 licensee respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

Upon review of the minutes of the Family Council minutes provided by the President, it was noted on November 13, 2014 that the Family Council was recommending that during outbreaks in the home, that communication be sent out to families in a proactive manner with the goal to assist staff in managing conflictual situation with families, therefore freeing staff to care for residents.

During an interview with the President of the Family Council on October 30, 2015, she indicated that at the November 13, 2014 meeting, the members asked the Administrator to provide clarification regarding visitation during an outbreak in the home as family members were finding the signs posted in the home confusing. She indicated that no response in writing was provided to the Family Council, and that information regarding outbreaks appeared in the home's newsletter "L'Écho du Foyer" published on February 15, 2015.

The Administrator indicated to the inspector on November 3, 2015 that he did not respond in writing within 10 days of receiving Family Council advice related to recommendations related to outbreak communication, as per legislation. [s. 60. (2)]

WN #22: 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 ensure that the licensee consults regularly with the Family Council, and in any case at least every three months.

During an interview with the President of the Family Council on October 30, 2015, she indicated that the council met twice in 2015: March 31 and September 21. She further indicated that the licensee had not consulted with the Family Council since the November 13, 2014 meeting when he attended to respond to questions from members.

The Administrator indicated to the Inspector on November 3, 2015 that he was not aware that he was expected to consult with the Family Council regularly, and at least every three months. He further indicated that the last time he consulted with the Family Council, was in November 2014 when he attended their meeting to answer questions.

On November 3, 2015 the Administrator confirmed the above information. He indicated that he was not invited to Family Council meetings in the last year and he was not aware that he was expected to consult with the council at least every three months. [s. 67.]

2. The licensee has failed to ensure that the licensee consults regularly with the Residents' Council, and in any case at least every three months.

During an interview with the President of the Residents' Council on November 5, 2015, she indicated that the Council met every three months. She further indicated that the licensee had not consulted with the Residents' Council.

The Administrator indicated to the Inspector on November 6, 2015 that he was not aware that he was expected to consult with the Resident Council regularly, and at least every three months, therefore had not met this requirement as per legislation. [s. 67.]

Issued on this 30 day of December 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

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JOANNE HENRIE (550) - (A1)

Inspection No. / No de l'inspection : 2015_289550_0025 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-002664-15 (A1)

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

Report Date(s) / Date(s) du Rapport : Dec 30, 2015;(A1)

Licensee / Titulaire de permis : GENESIS GARDENS INC
438 PRESLAND ROAD, OTTAWA, ON, K1K-2B5

LTC Home / Foyer de SLD : FOYER ST-VIATEUR NURSING HOME
1003 Limoges Road South, Limoges, ON, K0A-2M0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Richard Marleau

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

To GENESIS GARDENS INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_289550_0025, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 228. Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:

1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,

i. the matters referred to in paragraph 3,

ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and

iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Order / Ordre :

The licensee must have a written description of the quality improvement and utilization review system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review. MOHLTC inspection reports should be used as a guide to prioritize quality improvement initiatives for 2015-2016.
The system must be ongoing and interdisciplinary.

The licensee shall provide a written progress report on February 25, 2016 and on April 21, 2016 to inspector Angèle Albert-Ritchie via email at OttawaSAO.MOH@ontario.ca .

Grounds / Motifs :

1. The licensee failed to ensure that the quality improvement and utilization review system under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its policies, procedures and protocols to identify initiatives for review.
2. The system must be ongoing
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Inspector #545 reviewed the home's Continuous Quality Improvement (CQI) manual. Upon review of the "Terms of Reference", it was indicated that the "committee" would develop an annual work plan to simplify and streamline quality improvement, activities, monitoring and reporting of care, such as to:
- Identify, categorize and prioritize issues for improvement
- Seek out, monitor and respond to quality and safety issues
- Identify emerging knowledge and evidence, trends or innovations
- Assess quality assurance, monitoring and auditing.

The Terms of Reference also indicated the committee would strive to meet weekly, and that a meeting must be held every two weeks, as well as reporting regularly to

Residents and Families on priorities, the targets identified and the plans to achieve them.

During an interview with the Administrator, he indicated to Inspector #545 that the home was still in the process of developing their quality improvement utilization review system. The Administrator indicated that the policies, procedures and protocols had not yet been developed.

The Administrator indicated that the CQI Committee had not met since June 23, 2015, as evidenced by minutes provided to the Inspector.

The Administrator further indicated to the inspector that in 2015, the home focused on improving care plans, and that other priorities had not been completed as planned in the home's internal plan developed in November 2014. He further indicated that the home did not monitor, analyze, evaluate and improve the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home, as identified in their plan, other than the residents' care plans.

Because a quality improvement and utilization review system is not fully implemented, functional and ongoing in the home, the licensee has issues with their infection control program and their minimizing of restraint policy which poses a high risk to their residents. There are also recurring non compliance in regards to dining and snack service, care plans, accommodation services, reporting certain matters to the director, restraining by physical devices, training of staff, the satisfaction survey, bed rails, reporting of critical incidents and safe storage of drugs.

Non-compliance under LTCHA, c. 8, s. 84 was previously issued as a written notification on May 31, 2012, and as a compliance order, inspection #2014_289550_0012 on November 7, 2014 with a compliance date of March 31, 2015. (545)

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

Jun 23, 2016

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

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2014_289550_0025, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
(c) that the local medical officer of health is invited to the meetings;
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

Order / Ordre :

The licensee will ensure:
-that there is an interdisciplinary team approach in the co-ordination and implementation of the Infection Control program that is in line with evidence-based practices or prevailing practices as per the Provincial Infectious Disease Advisory Committee (PIDAC) with a focus on establishing clear policies and procedures related to antibiotic resistant organism such as MRSA and VRE.
-the infection control team meet quarterly
-the evaluation of the program is included in the quality improvement and utilization review system

The licensee shall provide a written progress report on February 25, 2016 and on April 21, 2016 to inspector Angèle Albert-Ritchie by email at OttawaSAO.MOH@ontario.ca.

Grounds / Motifs :

1. 1. The licensee has failed to ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the infection control program;
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
(c) that the local medical officer of health is invited to the meetings;
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Inspector #550 reviewed the Infection Control program manual that was provided by the ADOC and noted the manual was signed as having been revised by the Infection Control nurse and was dated September 2015. Upon a review of the said manual, Inspector #550 observed that many of the home's policies were old and not updated to reflect current best practices.

Inspector #550 interviewed the Infection Control nurse. She indicated she did not

participate in the evaluation and the update of the Infection Control program as this was assigned to the Director of Care (DOC) and the previous ADOC. She indicated to inspector she reviewed and signed the Infection Control policies in the manual in September 2015 because the home was scheduled to have their Accreditation and this needed to be completed for Accreditation purposes. She further indicated she did not use the best practices from PIDAC when she reviewed the policies.

During an interview the DOC indicated she was involved in the revision and update of the Infection Control program with the former ADOC but from a distance. The DOC indicated that she is unsure of what was completed and what still needs to be done and that the former ADOC has left the home since August 2015. She indicated they referred to the best practices document from Provincial Infectious Disease Advisory Committee (PIDAC) and that she has this document for reference.
Inspector #550 observed that resident #025 and #043 both had a contact to contact precaution sign posted at their bedroom entrance next to the door. No hamper was observed in either resident's bedroom for staff to dispose the contaminated gowns. There was no isolation cart containing the proper personal equipment available to staff to wear when caring for those two residents inside or outside of the resident's bedroom. Inspector observed resident #025 had a few isolation gowns in the last drawer of the bedside dresser but resident #043 had none. A review of both residents' health records indicated residents #025 was diagnosed with a specific infectious disease since his/her admission on a specific date in July 2015 and resident #043 was also diagnosed with another specific infectious disease on a specific date in September 18, 2015. Both residents require special precautions in place due to these infectious diseases.
During an interview, PSW staff #S127 indicated to Inspector #550 there usually is a hamper in resident #025 and #043's bathroom but there were none at the time of the interview and she had to walk outside of the resident's rooms to the hamper in the hallway to dispose of the contaminated linen in the hamper that is kept in the hallway. They do not have any personal protective equipment (PPE) in both residents' rooms except for the isolation gown in resident #025's bedside dresser. She indicated she had to get all of the PPE in the isolation cart that is kept in the tub and shower room.

PSW #S126 indicated to Inspector #550 she was the PSW assigned to resident #025 and #043 and that when she provides direct care for these two residents she has to wear gloves. Inspector #550 showed PSW# S126 that the contact to contact precaution sign at the entrance of the bedroom door for resident #025 and #043

indicated hand washing, gloves, gown and dedicated personal equipment. When inspector pointed out that on the contact precaution sign for resident #025 both the gloves and gown were circled, PSW #S126 indicated that she forgot but she also needs to wear a gown with the gloves when providing direct care to this resident but that no other precautions are required. She further indicated that because there is nothing circled on the contact to contact precaution sign at resident #043's bedroom door entrance, she only has to wear gloves when providing care to this resident, no other precautions are required.

RPN #S125 indicated to Inspector #550 during an interview that when staff is caring for resident #025 they have to be careful and when the resident has a cold, they have to wear a mask and goggles. During any other time they have to perform hand washing only. When staffs are caring for resident #043, they have to use universal precautions and wear gloves when providing pericare. She indicated the PSWs have to wear a gown when they are providing direct care to the resident and the nurse also has to wear a gown and gloves when she is changing the resident's dressing and perform hand washing after.

RPN staff #S125 indicated to Inspector #550 they do not have dedicated equipment as it is indicated on the contact to contact precaution sign. She indicated when she has to share a piece of equipment such as a sphygmomanometer with other residents in the home; she will clean this equipment with alcohol swabs after using it with this infected resident.

Inspector #550 reviewed the actual plan for both resident and observed there was a separate sheet for both residents in their health records as part of the written care plan for theses residents and observed it was revised and printed on November 3, 2015.
Inspector interviewed the Infection control nurse who indicated that after our discussion the day before, she looked in these two resident's written plan of care and observed their plan of care had not been revised and updated to reflect their infectious disease. She then updated resident #025 and #043's written plan of care to reflect their infectious disease and printed them for staff.

During a revision of resident #025's plan of care Inspector #550 observed the interventions listed indicated:
-a specific infectious disease precautions in effect

-Resident #025 has had 2 negative results
-Resident #025 must have 3 negative cultures taken at least 1 week apart.

During an interview, the Infection Control nurse indicated to Inspector #550 that the home's policy for MRSA which is the policy staff should refer to guide them for the "MRSA precautions in effect" is kept in the infection control manual located in the infection control nurse. The infection control manual is kept in the Infection Control nurse's locked office. When she is not working, the PSW's do not have access to her office.

The ADOC indicated to Inspector #550 only the managers have access to the office of the Infection Control nurse where the Infection Control policies manual is located. [s. 229. (2)] (550)

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

Jun 23, 2016

Order # /
Ordre no : 003

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

Linked to Existing Order /
Lien vers ordre existant: 2014_289550_0025, CO #004;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The Licensee will:
-develop and implement procedures for routine and remedial maintenance
-address all areas of concerns described in the grounds of this Compliance Order
-develop audit tools, conduct regular audits of residential areas in the home and evaluate the efficiency of the actions taken to resolve the deficiencies through the home's quality improvement and utilization review system.

The licensee shall provide a written progress report on February 25, 2016 and on April 21, 2016 to inspector Angèle Albert-Ritchie by email at OttawaSAO.MOH@ontario.ca.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the equipment is kept clean and sanitary.

During the resident observation Inspectors #550, #545 and #592 observed several resident's ambulation equipment to be unclean on October 27, 28, 29 and 30, 2015 as follows:

resident #022's wheelchair seat cushion was soiled with streaks of liquids,
resident #003's wheelchair both arm rests were covered with dried up debris and whitish film, the seat belt was covered with white stains and dried up food and the wheelchair frame was covered with dust and some dried up food,
resident #006's seat belt from the loaned wheelchair was covered with dried debris, and
resident #009's wheelchair frame was dusty, there were some debris stuck to the frame around the brake system and on the right foot rest.

The ADOC indicated to Inspector #550 during an interview that the PSWs are required to clean the residents' ambulation equipment as per the schedule posted in the tub and shower rooms and sign the sheet when they have completed the task. She further indicated if the sheet is not signed, it means the task was not done. If a resident's ambulation equipment becomes dirty between the scheduled cleaning routine, the home's expectation is that the PSW caring for the resident will do a quick clean up of the chair and will then leave a note in the report book for the PSW working the 1:00PM to 9:00PM shift to do a thorough cleaning.

Inspector #550 and the ADOC observed that all the resident's ambulation equipment as noted above remained unclean.

Inspector #550 reviewed the report book from October 25 to 30, 2015 and observed there was no documentation regarding cleaning of mobility equipment for any of those residents.

Inspector #550 and the ADOC reviewed the sheets posted in the tub and shower rooms that the PSWs have to sign after they have cleaned a resident's ambulation equipment for the month of October, 2015. It was observed that there was no documentation for resident #022 and that this resident is not on the cleaning schedule. The ADOC indicated this resident has been using a wheelchair for only 5 days but the PSW's should have cleaned the seat cushion as soon as they noticed it was unclean. There was no documentation for resident #003 and #009. It was documented resident #006's wheelchair was cleaned weekly and the last time was 2 days ago. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On October 28th, 2015, Inspector #592 observed in a shared bathroom between two (2) specific rooms a grabbing bar on each side of the toilet. When inspector #592 touched the grabbing bars, both of them were wobbling and not fix to the ground, posing a risk to the safety of the residents who are using the grabbing bars.

Upon showing the grabbing bars on each side of the toilet to PSW #121, she told inspector #592 that both grabbing bars are being used for three of the four residents who are sharing the bathroom to provide them stability and assistance when they are

getting up from the toilet.

On November 02, 2015, upon showing the grabbing bars to the environmental manager, he indicated that the grabbing bars were safe for residents but that they were maybe loose and that he would try to purchase new ones. He further indicated that Resident #022 was not using the toilet alone, therefore lowering the risk of any injuries.

Upon a review of resident #022 health care records, it is indicated that resident #022 has poor weight bearing with unsteady gait. It is further noted in the progress notes that on November 02, 2015, Resident #022 went to the bathroom on his/her own a few times and was at risk for falls.

On November 02, 2015, upon showing the grabbing bars to the ADOC, she told inspector #592 that the grabbing bars were unsafe and were putting residents at risk and should be replaced with safer ones. (550)

2. 3. From October 26 to November 6, 2015 the following areas of disrepair were observed and noted
-walls in bathroom in room 102 were damaged
-caulking around the toilet in room 102 was missing
-floor tiles around the toilet in bathroom in room 107 were stained
-floor tiles under the baseboard heaters in the small dining room were broken where the sub floor raised up exposing the cement sub-floor where dust and debris have accumulated
-well-worn varnish on the wooden handrails in the hallways exposing the wood grain
-floor tiles under the baseboard heaters in room 120 were broken where the sub floor raised up exposing the cement sub-floor where dust and debris have accumulated
-there were 2 vinyl lazy boy chairs in the television lounge with ripped vinyl exposing the material and foam underneath
-baseboard heaters in both dining rooms were dented with paint scuffed in several areas and rusted.
-resident #005 and #008: Inspector #545 observed the sink drain in the resident's shared washroom was rusted
-resident #010: Inspector #545 observed the sink drain in the resident's washroom was rusted. Inspector #592 observed the call bell button to be removed from its

socket, exposing the inside mechanism of the call button.

Inspector #550 toured the home with the Administrator and it was observed that many of the issues identified in September 2014 were the same issues identified above such as:
-walls in bathroom in room 102 were damaged
-caulking around the toilet in room 102 was missing
-floor tiles around the toilet in bathroom in room 107 were stained
-floor tiles under the baseboard heaters in the small dining room were broken where the sub floor raised up exposing the cement sub-floor where dust and debris have accumulated
-well-worn varnish on the wooden handrails in the hallways exposing the wood grain
-floor tiles under the baseboard heaters in room 120 were broken where the sub floor raised up exposing the cement sub-floor where dust and debris have accumulated
-there were 2 vinyl lazy boy chairs in the television lounge with ripped vinyl exposing the material and foam underneath
-baseboard heaters in both dining rooms were dented with paint scuffed in several areas and rusted.

The Administrator was disappointed to see that some of the identified areas of disrepair last year were not addressed. He indicated to the inspector he had given the report to his maintenance person thinking he would repair every area identified in the report. He further indicated the maintenance supervisor was on a leave for 2 months but that he should have informed the Administrator what was not done.

The Administrator indicated to the inspector he was not aware of any of the areas in disrepair identified during this RQI. He indicated that when staff observes an area in need of repair they will write a note in the maintenance book for the maintenance person to address and repair. He indicated he conducted a high level audit of the home on a monthly basis to identify some areas in need of repair but that sometimes he does not see all the areas in need of repair as he's in the home on a daily basis. Inspector #592 reviewed the maintenance log book from November 2014 to this day and observed that the rusted sink drain in bathroom #107 and #102 and the defective call bell in room #102-4 were not reported for repair.

The Administrator showed inspector #550 a schedule for routine, preventative and remedial maintenance which he identified as a schedules for routine, preventative and remedial maintenance. This was a chart with tasks to be done on a daily,

weekly, monthly and quarterly basis and once the tasks were completed, the maintenance person checked the corresponding box to indicate it was done.

The Administrator further indicated he did not develop and establish any procedures for the routine and remedial maintenance to ensure ongoing maintenance for home repair and he did not think of asking for an extension to the compliance date.

Non-compliance was previously issued under LTCHA, S.O. 2007 as a voluntary plan of correction on May 31st, 2012 and as a compliance order on November 7, 2014. (550)

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

Jun 23, 2016

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Order / Ordre :

(A1)
The licensee shall ensure that there is a written policy to minimize the restraining of residents and ensure that any restraining that is necessary is done in accordance with section 29 (1) (a) and (b) of the Act, and with requirements as may be provided for as per sections 109, 110, 111, 112 and 113 of the regulations, and ensure that the policy is complied with.

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA s. 29 (1) (a) and (b) through the following actions:

1. Develop a Policy to Minimize Restraining of Residents based in accordance with the following sections of the regulations:
-s. 109; Policy to minimize restraining of residents, etc
-s. 110; Requirements relating to restraining by a physical device
-s. 111; Requirements relating to the use of a PASD
-s. 112; Prohibited devices that limit movement
-s. 113; Evaluation

2. Provide and document training to all staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices, as per sections 221 (5) and for staff who apply Personal Assistive Services Devices (PASDs) or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs, as per section 221 (6)

3. Consider and document alternatives to the use of physical devices for Resident #005, #010 and #029, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach

4. Document assessment of all residents restrained by physical devices and or PASDs

5. Review and update the written plan of care of each resident restrained by physical devices and or PASDs, setting planned care, goals the care is intended to achieve and clear directions to staff and others who provide direct care to these residents

6. Implement a monthly evaluation process which will include documented

audits of direct observation of residents restrained by physical devices and or PASDs, to ensure compliance with the home's new policy to minimize restraining of residents, that will be evaluated through the Quality Improvement and Utilization Review System

This plan must be submitted in writing to inspector Angèle Albert Ritchie, LTCH Inspector on January 8, 2016 by email at OttawaSAO.MOH@ontario.ca then a written progress report shall be provided on February 25, and on April 21, 2016.

Grounds / Motifs :

1. 1. Policy to minimize restraining of residents
The licensee failed to ensure that the home's written policy under section 29 of the Act deals with,
• restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others;
• types of physical devices permitted to be used;
• how consent to the use PASDs as set out in section 33 of the Act is to be obtained and documented
• alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach
• how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation.

The Long Term Act indicates that a physical restraint includes all devices used by the home that restrict freedom of movement or normal access to one's body. A resident may be restrained by a physical device if the restraining of the resident is included in the resident's plan of care. The use of a physical device from which a resident is both physically and cognitively able to release themselves is not a restraining of the resident. The Resident Assessment Instrument (RAI) defines a physical restraint as: "as any manual method, or any physical or mechanical device, material, or equipment, that is attached or adjacent to the person's body, that the person cannot remove easily, and that does, or has the potential to restrict the resident's freedom of movement or normal access to his or her body.

The Inspector reviewed the Home's policy: Least Restraints Policy Resident Safeguard, with a revision date of June 2013 as indicated by the Assistant Director of Care (ADOC).

During an interview with the DOC, she indicated that the home's Least Restraints Policy Safeguard had been reviewed in June 2013 based on the Ministry of Health and Long Term Care Standards dated November 2004 (Document #0809-01), which do not include all requirements as per the Long Term Care Act, 2007 and regulations.

Inspector #545 determined that the policy did not contain all the requirements under sections 109 through 113 of the Ontario Regulations 79/10 (Policy to Minimize Restraining of Residents).

The Policy did not indicate:
(c) Restraining under the common law duty pursuant to subsection 36 (1)
of the Act when immediate action is necessary to prevent serious bodily harm to the person or
others;
(d) Types of physical devices permitted to be used;
(e) How consent to the use of PASDs as
set out in section 33 of the Act is to be obtained and documented;
(f) Alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and
(g) How the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation.

Mandatory Annual Training and Training at Orientation in the area of the home's policy to minimize the restraining of residents

During resident observations conducted as part of Stage 1 of the Resident Quality Inspection (RQI), several residents were observed in wheelchairs with one, two and three restraints. As a result of these observations LTCH Inspector #545 interviewed staff, about the training they received, specifically related to restraints and personal assistive services devices (PASDs), reviewed residents' health records and the home's least restraint policy.

Restorative Care/PSW #114 indicated that she believed that restraint training was provided by the home's occupational therapist that visits the home monthly. She was unable to recall the date when the training was last provided.

PSW #110 and PSW #107 who have been employees in the home for more than 20 years indicated that they had not received training on restraints and PASDs. PSW #107 thought that a physiotherapist had provided a session approximately five years ago. RN#101, who has worked in the home for three years indicated that she did not receive training on restraints and PASDs, not upon hire and not annually.

In an interview with the Education Lead, she indicated that training on restraints and PASDs had not been provided to direct care staff, including registered staff for at least four years, added that she was not aware that this training was required annually. She further indicated that the home's orientation program did not include training on restraints and/or PASDs.

During an interview with the DOC on November 3, 2015 she indicated that the home did not provide training to staff who apply physical devices and/or PASDs or who monitor residents restrained by physical devices and/or PASDs, training in the application, use and potential dangers of these physical devices, upon hire and annually as per legislation.
Restrained by physical device not included in resident #029's plan of care
Resident #029 was admitted to the home on a specific date in the winter of 2011 with several medical conditions including stroke and depression and had an amputation of a specific body part and seizure disorder. According to the most recent assessment dated October 7, 2015, the resident was dependent for all activities of daily living, was wheelchair bound and wheeled by others, and had no trunk restraints or was not in any chairs preventing rising.

Upon review of the most recent plan of care (dated a specific date in August 2015), it was indicated that resident #029 had a front fastening seat belt when in his/her wheelchair. The note also indicated that the front fastened seat belt was not used as a restraint.

On October 28, 29 and November 2, 2015 the inspector observed resident #029 in a tilt wheelchair with a 4-point front fastened seat belt as well. When asked if could release the front fastened seat belt, the resident was physically unable to, it is to be noted that the resident's specified limb was paralyzed and resting on a quarter

padded resting device.

PSW #122 indicated that the resident had a front seat belt when in his/her wheelchair, and she did not think the resident was able to remove it anymore, that it was applied to prevent him/her from falling. The PSW indicated that that she did not believe the Resident was able to remove the front fastening seat belt.

RPN #125 indicated that the resident was used for safety, prevention of falls and positioning. Indicated that the resident use to try to get out of the wheelchair but in the last year, did not make any attempts. The RPN indicated that that she did not believe the resident was able to remove the front fastening seat belt.

During an interview with the ADOC, she indicated that the most recent plan of care did not provide clear directions to staff related to a physical restraint such as a front fastening seat belt, used daily for resident #029.

Resident #010's physical device was not applied in accordance with instructions specified by the physician

Resident #010 was admitted with several medical conditions including Alzheimer's Disease with severe cognitive impairment and a specific eye disease. According to the most recent assessment the resident was assessed as not having a trunk restraint.

During observations on October 27, 29 and 30, 2015, Inspector #545 observed resident #010 in a tilt wheelchair, with a front closure seat belt including a padded table tray. When asked, the resident was physically and cognitively unable to remove the table tray and release front closure seat belt.

Upon review of the resident's health record, it was documented in the quarterly medication review dated a specific date in September 2015 by the physician that the following safety devices were prescribed:
- Lap belt to wheelchair (front fastening) PRN (as needed) for safety and provide rest period
- Table tray to wheelchair or rock chair PRN (as needed) for safety and provide rest period

In a review of the Restrictive Devices: Monitoring/Repositioning Record for the month

of October 2015, it was documented that resident #005 had a front fastening lap belt and a table tray to his/her wheelchair from 0700 to 2000 or 2100 each day. There was no indication that the restraints were applied as per physician's order such as application as needed and provision of rest period.

During an interview PSW/Restorative Care #114, she indicated that the resident had a front fastening seat belt and a padded table tray at all times, not as needed as per the doctor's orders. She indicated that the resident did not receive rest periods, other than on the 8 specified days in October 2015 that he was walked by two staff.

PSW #103 indicated on October 30, 2015 that the resident had a front fastening seat belt and a table tray to prevent falls. The PSW indicated that the resident had these restraints to prevent falls and for his/her safety, added that she was not aware of recent falls or if the resident made attempts to get out of his/her wheelchair. She further indicated that the front fastening seat belt and table tray were applied in the morning when resident was transferred to the wheelchair for breakfast. She indicated that the resident did not rest after breakfast or after lunch, and that he/she watched TV in the lounge and/or his/her room.

The ADOC indicated that resident #010 was not provided rest periods from front fastening seat belt and table tray on day and evening shifts. She further indicated that the physical devices were not applied in accordance with instructions specified by the physician.

No physician order or consent by SDM for restraining by physical device for resident #005.

On October 28, 29 and 30, 2015 Inspector #545 observed resident #005 in a tilt wheelchair with a front fastened seat belt as well as a clear plastic tray table fastened at the back of the wheelchair. On 2 occasions the resident was asleep in front of the TV in the lounge and on another occasion, the resident was asleep in his/her bedroom by the bed.

In a review of the resident's health record, orders by a physician or registered nurse in the extended class and consent by the resident's Substitute Decision Maker (SDM) for a tray table with rear fasten was not found.

The most recent Plan of Care dated a specific date in October 2015 indicated that

the resident used a tilt wheelchair, a tray table, foot rests and front fastening belt. There was no indication that the tray table was fastened at the back of the wheelchair.

During an interview with PSWs #116 and #103, they indicated that the resident had a tray table with a rear fasten to the back of the chair. Both PSW indicated that the seat belt and the tray table were used for the resident's safety and to prevent falls, as well as to place the drinks at snack time and to rest his/her arms. PSW #116 indicated that she thought that the resident sometimes put his/her hands under the tray and pushed it out of the way.

The ADOC indicated on October 30, 2015 that staff was applying on a daily basis a physical device, such as a tray table with rear fasten which resident #005 was unable to release. The DOC further indicated that the restraint by physical device had not been ordered or approved by a physician or registered nurse in the extended class and consent by the SDM had not been received, as per legislation.
resident #005 and #029's condition was not reassessed and the effectiveness of the restraining not evaluated, in accordance with the requirements provided for in the regulations.

On October 28, 29 and 30, 2015 Inspector #545 observed resident #005 in a tilt wheelchair with a front fastened seat belt as well as a clear plastic tray table fastened at the back of the wheelchair. On 2 occasions the resident was asleep in front of the TV in the lounge and on another occasion, the resident was asleep in his/her bedroom by the bed.

In a review of the quarterly physician orders, it was documented that the following restraints were prescribed since admission on a specific date in the fall of 2012:
-Safety: Lap belt (front fastening) to wheelchair for safety & optimal positioning
-Safety devices: 2 bedside rails up for safety

The most recent Plan of Care dated a specific date in October 2015 indicated that the resident used a tilt wheelchair, a tray table, foot rests and front fastening belt. It was also documented that the resident was at medium risk for falls.

A consent signed by the resident's family member on a specific date in the fall of 2012 indicated that a safety lap belt (front fastening) and two beside rails would be used to increase the resident's safety due to a loss of muscle tone, decrease

mobility, incontinence, constipation and altered circulation. Benefits were documented as: reduction in risk of falls and provision of sense of security. No other assessment of methods of restraining was found in the resident's health record.

During an interview with the Restorative Care staff #S114 she indicated that the physiotherapist should have reassessed the resident's restraints to address the risk, however she was unable to provide evidence of this. She further indicated that the resident was admitted with all three restraint methods: tilt, front fastened seat belt and rear fastened tray table.

The ADOC indicated during an interview on October 30, 2015 that resident #005's methods of restraining had not been re-evaluated since the resident's admission in 2012 to address the risk. The ADOC further indicated that she was not aware of any recent falls or attempts to get out of the wheelchair for resident #005 and that in his/her present condition, resident #005 probably no longer required some of these restraints.

On October 28, 29 and November 2, 2015 the Inspector observed resident #029 in a tilt wheelchair with a 4-point front fastened seat belt as well. When asked if could release the front fastened seat belt, the resident was physically unable to, it is to be noted that the resident has a paralysis to a specific limb and it was resting on a quarter padded device.
In a review of the quarterly physician orders (September 2015), it was documented that the following restraints were prescribed, since March 2015:
-Safety: Lap belt (front fastening) to wheelchair for safety & optimal positioning
-Safety devices: 2 bedside rails up for safety

The most recent Plan of Care dated a specific date in September 2015 indicated that the resident had a front fastening seat belt when in wheelchair for optimal positioning; not used as a restraint. There was no mentioning of the use of a tilt wheelchair, preventing the resident from rising.

A consent signed by the resident's family member on a specific date in December 2011 indicated that a 4-point belt would be used to improve posture support and comfort and reduce risk for falls and injuries. There was no documentation indicating that the resident's condition was reassessed and the effectiveness of the restraining re-evaluated since his/her admission in 2011.

PSW #122 indicated that resident #029 had a front fastened seat belt and was in a tilt wheelchair, she further indicated that the resident was unable to release the seat belt and she had never seen him/her making attempts in getting out of the wheelchair.

The ADOC indicated during an interview on November 2, 2015 that resident #029's methods of restraining had not been re-evaluated since his/her admission in 2011 to address the risk and/or effectiveness of the restraining devices. The ADOC further indicated that she was not aware of any recent falls or attempts to get out of his/her wheelchair and that in this present condition, resident #029 may require a re-evaluation the restraining by physical devices.

No alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach for residents #005, #010 and #029. These residents were observed restrained by physical devices between October 26 and November 6, 2015.

A review of these residents' health record was conducted and documentation of alternatives to the use of physical devices, including how these alternatives were planned, developed and implemented, using an interdisciplinary approach, was not found.

Resident #005's Physical and/or Chemical Restraint Consent Form indicated on a specific date in November 2012 that options discussed were two bed rails raised for resident's safety and a front fastened seat belt when in wheelchair for safety and optimal position.

Resident #010 Physical and/or Chemical Restraint Consent Form indicated on a specific date in January 2014 that options discussed were front seat belt when in wheelchair for safety and rest as needed and table tray when in wheelchair or in rocking chair for safety and rest as needed.

Resident #029 Physical and/or Chemical Restraint Consent Form indicated on a specific date in December 2011 that options discussed were a 4-point seat belt and two full bed rails be used as physical restraints.

The DOC confirmed that alternatives to the use of physical devices, including how these alternatives were planned, developed and implemented, using an

interdisciplinary approach, was not done for the above three residents.

It is noted that this area of non-compliance related to Minimizing of Restraints was previously issued as Voluntary Plan of Correction (VPC) during the RQI 2014. (550)

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

Jun 23, 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

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

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

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

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 30 day of December 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JOANNE HENRIE - (A1)

Service Area Office /
Bureau régional de services : Ottawa