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
Feb 25, 2016;	2015_214146_0015 (A3)	H-002399-15	Resident Quality Inspection

Licensee/Titulaire de permis

HENLEY HOUSE LIMITED
200 RONSON DRIVE SUITE 305 TORONTO ON M9W 5Z9

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

THE HENLEY HOUSE
20 Ernest Street St. Catharines ON L2N 7T2

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

BARBARA NAYKALYK-HUNT (146) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

CO #001 related to resident rights was rescinded. The findings were included in other areas of the report.
Compliance dates were extended for all other orders.

Issued on this 25 day of February 2016 (A3)

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

Original report signed by the inspector.

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

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): August 24, 25, 26, 27, 28, 31, September 1, 2, 3, 4, 9, 10, 11, 14, 15, 16, 17, 2015

Inspections conducted concurrent with this RQI included: complaint inspections #009048-14, 005457-14, 005845-14, 011733-15, 006841-14, 008901-14, 003804-14, 005459-14, 006574-14, 009247-14, 009239-15, 017411-15, 012969-15, 000589-14, 000624-14, 009842-15, 005845-15, 007884-14, 008898-14, 002741-15, 025362; Follow-up inspections #007577-15, 007578-15, 007581-15, 007584-15, 007587-15, 021613-15; Critical Incident inspections #024348-15, 021208-15, 016453-15, 00469 -15, 0013732-15, 021963-15, 015375-15, 005378-15, 009048-15, and 018681-15. Any findings of non-compliance from these inspections will be included in this report with the exception of complaint inspections #01969-15 and 17411-15 which will be included in their own inspection reports.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care; Acting Director of Care; Director of Informatics & Quality; Director of Clinical Services; Labour Relations Consultant; Resident Assessment Instrument (RAI) Coordinator; Social Worker; registered staff; Personal Support Workers (PSW's); Food Services Manager (FSM); Environmental Manager; Life Enrichment/Recreation Manager; recreation staff; restorative staff; dietary staff; housekeeping staff; hairdressing staff; residents and family members. During the course of this inspection, the inspectors: toured the home; reviewed meeting minutes and internal investigation notes; reviewed policies and procedures; reviewed resident health records; and observed residents in dining and care areas.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

15 WN(s)
3 VPC(s)
4 CO(s) 0
DR(s) 0
WAO(s)

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

WN #1:

Additional Required Actions:

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

(A3)The following order(s) have been rescinded: CO# 001

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

Specifically failed to comply with the following:

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

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

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out (c) clear directions to staff and others who provided direct care to the resident.

A) Resident #430's current plan of care, indicated that the resident preferred certain interventions at certain times. Another section of the plan of care directed staff to provide different interventions at different times related to the same need. The plan of care contained unclear directions to staff related to the resident's specific care. This was confirmed by the staff and the health record.

B) A review of resident #504's health record indicated that the resident was to be provided a specific intervention. A review of the same written care plan under another focus, indicated that the resident did not require the intervention. Interviews with the Director of Informatics & Quality and PSW's confirmed that the written plan of care did not set out clear directions to staff and others who provided direct care to the resident. (214) [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.
s. 6. (2)

Resident #305's health record indicated that the resident's assessments related to a specific function had deteriorated since admission. Review of the care plan revealed the absence of specific interventions that would facilitate the resident's ability to improve related to that specific function. The ADOC confirmed it would be the home's expectation that a plan to restore the identified function would be put in place and that the plan of care was not based on an assessment of the resident and the resident's needs and preferences. [s. 6. (2)]

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

Resident #009's MDS assessments dated April 2015 and July 2015 in section I2g indicated that the resident had a respiratory infection. Progress notes reviewed from January 1, 2015 to present contained no mention of respiratory symptoms. Physician notes reviewed from January 1, 2015 to present contained no mention of respiratory symptoms. Registered staff on the unit stated that the resident has had no respiratory infection in past year or more. The MDS assessments are not consistent with the medical and nursing staff assessments. This was confirmed by health record, registered staff and the informatics nurse. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A) Resident #010's health care record indicated that medications were changed in July 2015. The resident's POA stated that there was no notification to the POA that the medications had been changed for the cognitively impaired resident. Registered staff stated that had the POA would normally be notified and that the check off box on the order sheet would confirm this. The registered staff confirmed that the check off box on the order sheet had not been completed and stated that this would support the statement that the POA had not been notified. The POA was not given an opportunity to participate fully in the development and implementation of the resident's plan of care.

B) In October 2013 cognitively impaired resident #603 had orders to change certain medications. Upon review of resident #603's clinical records, consent was never obtained from the POA for these noted changes. Registered staff also confirmed consent was not obtained. (611) [s. 6. (5)]

C) A review of resident #203's care plan identified that a specific intervention was not to be used as per the resident and family's request. The progress notes documented in September 2015 showed that the intervention was used. Staff confirmed that the intervention was used. In an interview with resident #203, the resident confirmed that the intervention was uncomfortable and the resident did not want it used. Registered staff shared that they were aware the family previously requested that the intervention not be used and it was confirmed that the substitute decision-maker (SDM) was not notified of this change. It was confirmed that resident #203 and the SDM were not provided an opportunity to fully participate in the development and implementation of their care plan. (583)

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

A) Resident #010's recreation care plan directed staff to encourage the resident to attend a specific activity. According to the attendance records, resident #010 had attended only one of twelve of the specific activities offered in the past six months. The recreation manager confirmed that the care had not been provided as set out in the plan of care.

B) Resident #010's recreation care plan directed staff to assist the resident to attend specific programs. According to the attendance records, resident #010 attended four

of twenty-four specific programs in the past six months. The recreation manager confirmed that the home had not provided care as set out in the plan of care to the resident.

C) Resident #010's recreation care plan directed staff to provide 1:1 visits. The recreation manager stated that the expectation was to provide weekly 1:1 visits. According to the attendance records, the staff had provided only one 1:1 visit in the past six months out of an expected twenty-four visits. The recreation manager confirmed that the home had not provided care as set out in the plan of care to the resident.

D) The plan of care stated that resident #004 enjoyed certain identified programs and directed staff to encourage and remind the resident to attend. When the attendance record was reviewed for the past six months, the recreation manager verified that resident #004 had attended one of twenty-four identified programs. No refusals were documented. The manager confirmed that the care as set out in the plan of care was not provided to the resident.

E) A review of resident #503's clinical record from February to September 2015, indicated that resident #503 sustained multiple falls during this time period. A review of the resident's written plan of care indicated that a specific device would be in place. An observation of the resident's room on in September 2015, indicated that the device was not in place. An interview with front line nursing staff confirmed that the device was not in place as required.

F) A review of a Critical Incident Submission (CIS) that was completed by the home indicated that in March 2015 resident #502 sustained an injury. A review of the resident's written plan of care, as well as a review of immediate actions taken to prevent recurrence in the CIS submission, indicated that the resident would be provided with a device to prevent further injury. In September 2015 the resident was observed without the device in place. Staff confirmed that the device was not used on the date of the observation.

G) A review of a Critical Incident Submission (CIS) that was completed by the home indicated that in March 2015, resident #502 sustained an injury. A review of the resident's health record indicated that staff were requested to obtain a referral to a specific department in the home. Interviews revealed that the referral had not been made. Care was not provided as specified in the plan. (214)

H) The plan of care for resident #010 directed staff to document a specific observation when providing an identified intervention. A review of the documentation indicated that this information was not documented. This was confirmed by direct caregivers, the ADOC and the health record.

I) A review of the plan of care for resident #203 identified that the resident required extensive assistance from two staff for certain activities. During an interview with resident #203 in September 2015, the resident confirmed that the care was not provided as specified in the plan of care. It was confirmed by the staff that resident #203's care was not provided as directed in the plan of care.

J) Resident #040's plan of care indicated that the resident required two staff to assist with a certain activity. On a date in June 2015 a staff person reported that a PSW was dressing the resident alone causing the resident distress. The care as set out in the plan of care was not provided. This was confirmed by the health record, the witness and the ADOC.

Additional Required Actions:

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

(A3)The following order(s) have been amended:CO# 002

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse by anyone.

A review of resident #202's health record for 2015 identified that resident #202 had increasing verbal and physical responsive behaviours from January 2015 and on. The resident was known to strike out at other residents. In April 2015, staff found resident #201 on the floor with a serious injury. Resident #201 reported being pushed to the ground by resident #202. Strategies to protect other residents from resident #202 were not put into place until after resident #201 was injured. This was confirmed by the health record and registered staff. (583)

Additional Required Actions:

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

(A3)The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. . All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. . Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

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

Findings/Faits saillants :

1. s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training in the areas mentioned below:
9. Infection prevention and control.

The home provided documentation which indicated that the previous order to provide infection prevention and control training to all staff including maintenance, housekeeping and laundry by June 1, 2015 was not complied with.
The home's documentation indicated that:
69% of housekeeping staff, 50% of maintenance staff and 66% of laundry staff did not receive the training. This was confirmed by the records and the ADOC. [s. 76. (2)]

2. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 1. Abuse recognition and prevention. 6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

The home provided documentation which indicated the following:

i) 36% of the staff listed who provided direct care to residents did not receive annual re-training on prevention of abuse and zero tolerance policy in past year. Not listed on the staff list were a hairdresser who had worked in the home for twelve years and a hairdresser who had worked in the home for one year. Both hairdressers reported in an interview that they had not ever received training related to zero tolerance and prevention of abuse.

ii) 25% of PSW's, 48% of RPN's and 31% of RN's did not receive annual re-training related to falls management in the past year

iii) 34% of PSW's, 45% of RPN's and 23% of RN's did not receive annual retraining related to continence care and bowel management in the past year.

This information was confirmed by staff interviews, the home's documentation and the ADOC. [s. 76. (7)]

Additional Required Actions:

CO # - 004, 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A3)The following order(s) have been amended:CO# 004,005

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

A) A review of a Critical Incident Submission (CIS) that was completed by the home indicated that in March 2014, staff observed resident #500 to have impaired skin integrity. Assessments were not completed until three days later. An interview conducted with the ADOC confirmed that a head to toe assessment should have been completed as soon as staff identified this resident's alteration in their skin integrity and that it was the home's protocol to complete a Risk Management assessment for all incidents upon identification of the incident. The ADOC confirmed that the home did not comply with their policy and protocol.

B) A review of a Critical Incident Submission (CIS) that was completed by the home indicated that in March 2014, staff observed that resident #500 had impaired skin integrity. Review of the resident's progress notes indicated that the resident's POA was not immediately notified of the resident's skin impairment as directed by the

home's protocol. An interview with the ADOC confirmed that the protocol in the home was to notify the POA immediately of any incidents and that home did not comply with their protocol.

C) A review of a CIS that was completed by the home indicated that in March 2015, resident #502 sustained a skin injury. A review of the resident's clinical record indicated that a Risk Management assessment for incidents as well as a head to toe assessment had not been completed for this resident's injury.
A review of the home's policy titled, Head To Toe Assessment (03-04 and dated with a revision date of November 2013) indicated the following:

i) Residents will have a Head to Toe Skin Care Assessment completed and documented by a Registered Staff member upon any significant change in condition.

ii) Head to Toe Skin Assessment in Point Click Care (PCC) – used to record any alterations observed and that the skin observation has been completed.

An interview conducted with the ADOC confirmed that a Head to Toe Assessment was to be completed as soon as staff identified this resident's alteration in their skin integrity and that it was the home's protocol to complete a Risk Management assessment for all incidents upon identification of the incident. The ADOC confirmed that the home did not comply with their policy and protocol.

D) A review of a CIS that was completed by the home indicated that in March 2015, resident #502 sustained an injury. A review of the CIS indicated, under long-term actions, that to prevent recurrence, the home would immediately implement a specific strategy. The home's records indicated that the strategy was not consistently completed as per their protocol. An interview with staff confirmed that the strategies had not been done on three dates in September 2015. The FSM confirmed that the home's protocol was not complied with. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #6: 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 was 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 the course of the inspection, the bath records for eleven residents were reviewed. Records indicated that residents #030, #307, #309, #310 and #311 (five of the eleven) did not receive a bath at least twice weekly, on at least one occasion each, during the month of August 2015. Any documented refusals were not counted in this review. This information was confirmed by the ADOC on August 31, 2015. [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 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, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

A) In August 2015, an unattended medication cart was found in the corridor. A pair of scissors was sitting on top of the cart. When registered staff returned, they confirmed the scissors should not be left accessible to all residents, but should have been placed in the drawer and locked in the medication cart.

B) On another date in August 2015, an unattended medication cart was found in the corridor. A pair of scissors was sitting on top of the cart. When the registered staff returned, they apologized for leaving the scissors on top of the cart and stated scissors should not be accessible to residents, rather, should be locked in the cart when not in use. The ADOC confirmed the above. [s. 5.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

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

A) During an interview, when reviewing resident #010's and resident #004's recreation attendance, the recreation manager stated that residents had refused to attend recreation activities on several occasions. No refusals or resident's responses were documented. The recreation manager confirmed that recreation staff were not documenting refusals for residents but the home's expectation was that the refusals should be documented.

B)A review of resident #503's health record from February to September 2015, indicated that resident #503 sustained multiple falls during this time period. A review of the resident's written plan of care indicated that certain interventions would be completed. An interview with PSW's confirmed that the interventions had been completed; however, had not been documented. An interview with the RAI Coordinator confirmed that no task had been created in Point Of Care to document the specified intervention. (214)

C) Resident #430 requested a certain intervention. Staff interviewed on the floor stated that the resident did receive the intervention. The health record of resident #430 did not indicate when or if the resident received the intervention. Staff confirmed that they provided the care but failed to document the care. This information was confirmed by the health record, staff and the ADOC. [s. 30. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that when the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A review of a Critical Incident Submission (CIS) that was completed by the home indicated that in August 2015, resident #503 sustained a fall with injury. A review of the resident's clinical record indicated that a post fall assessment had not been completed for this fall. An interview with the Director of Informatics & Quality confirmed that a post fall assessment had not been completed for this resident when they sustained a fall with injury. [s. 49. (2)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

Resident #305's health record revealed a continence assessment reported the resident was continent. The continence assessment completed at a later date, reported the resident was incontinent. The assessment did not include causal factors, patterns, type of incontinence, and potential to restore function, with specific interventions. The above was confirmed by registered staff and by the ADOC. [s. 51. (2) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure strategies were developed and implemented to respond to residents who demonstrated responsive behaviours, where possible.

A) In April 2015, resident #201 reported being pushed and injured by resident #202. A review of the health record identified that resident #201 was agitated and wandering into resident's rooms. The health record identified that resident #201 was verbally and physically responsive to staff. The care plan and the units "Responsive Behaviour Worksheets" did not identify that resident #201 had verbal and physical responsive behaviours and wandered. In an interview with registered nursing staff and the Social Worker, it was confirmed that strategies were not developed and implemented to respond to resident #201's responsive behaviours.

B) A review of resident #202's progress notes identified that resident #202 had verbal and physical responsive behaviours from January 2015 and on. The care plan and the units "Responsive Behaviour Worksheets" up until April 7, 2015, did not identify that resident #202 had verbal and physical responsive behaviours towards other co-residents. The resident's physically responsive behaviours resulted in a co resident being injured. In an interview with registered nursing staff and the Social Worker in September 2015, it was confirmed that strategies were not developed and implemented to respond to resident #202's responsive behaviours. (583) [s. 54. (b)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 71(3)(a) Menu planning

The licensee shall ensure that each resident is offered a minimum of (a) three meals daily. 71(3) (a)

On a date in September 2015, resident #007, who was identified by the home as a moderate nutritional risk, was denied breakfast and entry to the dining room by an identified nurse according to a staff person's report to the LTC inspector. The resident arrived for 0830 breakfast at 0845 hours. The resident received no meal or food on the date in September 2015 until lunch time. The resident confirmed this information. This information was confirmed by a staff member who witnessed the incident. According to the resident and the staff, the resident was offered no alternative to the missed meal. The resident was not offered three meals on this date in September 2015. 71(3)(a) (146)

WN #13: 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:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were provided with eating aids required to eat and drink as comfortably and independently as possible.

A review of the plan of care for resident #200 identified they required the use of eating aids during meals. During a lunch observation in September 2015, resident #200 was not provided with the eating aids. In an interview with the dietary staff and the FSM it was confirmed that resident #200 was not provided with their required eating aids. (583) [s. 73. (1) 9.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person is taken to hospital.

Clinical record review revealed that on a date in August 2014, resident #303 was sent to hospital with an injury. The resident returned to the home with treatment to the injury. Three days later, resident #303 returned to hospital where they were admitted and treated for a different injury. The resident returned to the home. Critical incident report #2909-000019-14, was submitted seven days later, reporting an injury to a resident for which the resident was taken to hospital. The administrator confirmed the critical incident report was not submitted within one day of either occurrence. [s. 107. (3) 4.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administered a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident.

Registered staff reported that resident #308 had a topical medication at their bedside and self-administered this topical medication. Review of the clinical record revealed the absence of an order for self-administration of the medication. Registered staff confirmed that self-administration of this medication had not been approved by the prescriber. [s. 131. (5)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Resident #306's medication administration record (MAR) for August 2015 demonstrated that the resident received pain medication as ordered. The current written care plan directed staff to administer pain medication as ordered and note the effectiveness. Review of the progress notes for August 2015 revealed no documentation of the effectiveness of the pain medication that was administered. In September 2015, the ADOC confirmed it is the home's expectation that the effectiveness of the medication be documented and that there was no evidence of documentation of the effectiveness of the pain medications for resident #306. [s. 134. (a)]

Issued on this 25 day of February 2016 (A3)

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : BARBARA NAYKALYK-HUNT (146) - (A3)

Inspection No. / No de l'inspection : 2015_214146_0015 (A3)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-002399-15 (A3)

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

Report Date(s) / Date(s) du Rapport : Feb 25, 2016;(A3)

Licensee / Titulaire de permis :
HENLEY HOUSE LIMITED
200 RONSON DRIVE, SUITE 305, TORONTO, ON, M9W-5Z9

LTC Home / Foyer de SLD :
THE HENLEY HOUSE
20 Ernest Street, St. Catharines, ON, L2N-7T2

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Heather Colyer

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

(A3)
The following Order has been rescinded:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his

or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant:

2014_247508_0033, CO #005;
2014_247508_0033, CO #006;
2015_323130_0010, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan, including but not limited to: taking residents to recreation programs as identified in their plan of care and documenting refusals; providing interventions as identified in the plan of care related to falls management and skin protection; following through with referrals as identified in the plan of care; providing assistance with personal care as specified in the plan of care; and documenting care provided as specified in the plan of care.

Grounds / Motifs :

(A3)
1. Previously issued December 2012 as a VPC; February 2013 as a VPC; December 2013 as a CO; July 2014 as a VPC; February 2015 as a CO; and July 2015 as a CO.

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

A) Resident #010 s recreation care plan directed staff to encourage the resident to attend a specific activity. According to the attendance records, resident #010 had attended only one of twelve of the specified activities offered in the past six months. The recreation manager confirmed that the care had not been provided as set out in the plan of care.

B) Resident #010 s recreation care plan directed staff to assist the resident to attend specific programs. According to the attendance records, resident #010 attended four of twenty-four specific programs in the past six months. The recreation manager confirmed that the home had not provided care as set out in the plan of care to the resident.

C) Resident #010 s recreation care plan directed staff to provide 1:1 visits. The recreation manager stated that the expectation was to provide weekly 1:1 visits. According to the attendance records, the staff had provided only one 1:1 visit in the past six months out of an expected twenty-four visits. The recreation manager confirmed that the home had not provided care as set out in the plan of care to the

resident.

D) The plan of care stated that resident #004 enjoyed certain specific programs. The plan of care directed staff to encourage and remind the resident to attend. When the attendance record was reviewed for the past six months ending August 31, 2015, the recreation manager verified that resident #004 had attended one of twenty-four of the identified programs. No refusals were documented. The manager confirmed that the care as set out in the plan of care was not provided to the resident.

E) A review of resident #503's clinical record indicated that resident #503 sustained four falls over several months in 2015. A review of the resident's written plan of care indicated that a specific device would be in place. An observation of the resident's room on a date in September 2015, indicated that the device was not in place. An interview with front line nursing staff confirmed that the device was not in place as required.

F) A review of a Critical Incident Submission (CIS) that was completed by the home indicated that in March 2015, resident #502 sustained an injury. A review of the resident's written plan of care, as well as a review of immediate actions taken to prevent reccurrence in the CIS submission, indicated that the resident would be provided with a device to prevent further injury. In September 2015 the resident was observed without the device in place. Staff confirmed that care set out in the plan of care was not provided to the resident as specified in their plan. (214)

G) A review of a Critical Incident Submission (CIS) that was completed by the home indicated that in March 2015, resident #502 sustained an injury. A review of the health record indicated that staff were requested to obtain a specific referral to a specific department in the home. Interviews revealed that the referral had not been made. Care was not provided as specified in the plan. (214)

H) The plan of care for resident #010 directed staff to document a specific observation when providing an identified intervention. A review of the documentation indicated that this information was not documented. This was confirmed by direct caregivers, the ADOC and the health record.

I) A review of the plan of care for resident #203 identified that they required extensive assistance from two staff for certain activities. During an interview with resident #203 in September 2015, the resident confirmed that the care was not

provided as specified in the plan of care. It was confirmed by the staff that resident #203's care was not provided as directed in the plan of care.

J) Resident #040 s plan of care indicated that the resident required two staff to assist with a certain activity. In June 2015 a staff person reported observing that a PSW was dressing the resident alone causing the resident distress. The care as set out in the plan of care was not provided. This was confirmed by the health record, the witness and the ADOC. (146)

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

Jun 01, 2016(A3)

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall protect residents from abuse by anyone, including resident #201 and shall ensure that residents are not neglected by the licensee or staff.

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

Grounds / Motifs :

(A3)
1. The licensee failed to protect residents from abuse by anyone.

A review of resident #202's health record for 2015 identified that resident #202 had increasing verbal and physical responsive behaviours from January 2015 and on. The resident was known to strike out at others. In April 2015 staff found resident #201 on the floor with a serious injury. Resident #202 reported being pushed down by resident #201. Strategies to protect other residents from resident #202 were not put into pace until after resident #201 was injured. This was confirmed by the health record and registered staff. (583) (583)

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

Apr 04, 2016(A3)

Order # /
Ordre no : 004

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

Linked to Existing Order /
Lien vers ordre existant:

2014_247508_0033, CO #002;
2014_247508_0033, CO #003;

Pursuant to / Aux termes de :

Ontario

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

LTCHA, 2007, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 9. Infection prevention and control.

The licensee shall provide mandatory training and annual retraining in the areas of infection prevention and control and prevention of abuse to all staff by February 1, 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

Grounds / Motifs :

(A3)
1. Previously issued: December 2013 as a VPC; and October 2014 as a CO.

The home provided documentation which indicated that the CO to provide infection prevention and control training to all staff including maintenance, housekeeping and laundry by June 1, 2015 was not complied with. The home s documentation indicated that:
69% of housekeeping staff, 50% of maintenance staff and 66% of laundry staff did not receive the training.
This was confirmed by the records and the ADOC. (146)

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

Jun 01, 2016(A3)

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Order / Ordre :

The licensee shall ensure that all staff who provide direct care to residents receive training and annual retraining related to: abuse recognition and prevention; falls management; and incontinence management by February 1, 2016.

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

Grounds / Motifs :

1. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: falls management and continence care and bowel management.

The home provided documentation which indicated the following:

i) 36% of the staff listed who provided direct care to residents did not receive annual re-training on prevention of abuse and zero tolerance policy in past year. Not listed on the staff list were a hairdresser who had worked in the home for twelve years and a hairdresser who had worked in the home for one year. Both hairdressers reported in an interview that they had not ever received training related to zero tolerance and prevention of abuse.

ii) 25% of PSW's, 48% of RPN's and 31% of RN's did not receive annual re-training related to falls management in the past year

iii) 34% of PSW's, 45% of RPN's and 23% of RN's did not receive annual retraining related to continence care and bowel management in the past year.

This information was confirmed by staff interviews, the home's documentation and the ADOC. (146)

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

Jun 01, 2016(A3)

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

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 25 day of February 2016 (A3)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BARBARA NAYKALYK-HUNT - (A3)

Service Area Office /
Bureau régional de services : Hamilton