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

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

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

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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
Jun 28, 2016;	2016_323130_0007 (A1)	006418-16	Resident Quality Inspection

Licensee/Titulaire de permis

HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE STONEY CREEK ON L8J 2J3

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

HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE STONEY CREEK ON L8J 2J3

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

GILLIAN TRACEY (130) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance order dates were amended due to the expiration of the previously issued compliance dates.

Issued on this 29 day of June 2016 (A1)

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

GILLIAN TRACEY (130) - (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): March 8, 9, 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, 29 and 30, 2016.

The following Critical Incident inspections: #007517-16 related to falls prevention, #000341-14 related to responsive behaviours, #033591-15 related to falls prevention, #035787-15 related to responsive behaviours, #000918-15 related to falls prevention, #001979-15 related to falls prevention, #009712-15 related to alleged abuse, #011133-15 related to responsive behaviours, #023727 -15 related to falls prevention, #029297-15 related to responsive behaviours, #033351-15 related to responsive behaviours, the following Complaint Inspections: #016007-15 related to resident care and meal service, #028184-15 related to resident care, #028804-15 related to resident care, #005213-16 related to resident care and the following Follow-up Inspections: #010492-15 related to plan of care, #011647-15 related to infection control, #011648-15 related to infection control, #011649-15 related to abuse training, were conducted simultaneously with this RQI.

During this inspection the home was toured, including random resident rooms and dining areas, air temperatures were monitoured, the following reviewed: air temperature logs, the home's sling management program , falls management program , continence program, skin and wound program, relevant policies and procedures, staff education attendance records, lift and transfer educational materials, clinical records, complaint logs and investigation notes. Residents, staff and families were interviewed and resident care and meal services were observed.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Staff Development Coordinator, Physiotherapist (PT), registered staff, personal support workers (PSWs), Environmental Services Supervisor, maintenance staff, housekeeping staff, dietary staff, President Residents' Council, President of Family Council, residents and families.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

18 WN(s)
12 VPC(s)
5 CO(s)
1 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 18.	CO #007	2014_214146_0005	130
O.Reg 79/10 s. 221. (1)	CO #001	2015_189120_0092	130
O.Reg 79/10 s. 229. (10)	CO #001	2015_250511_0005	130
O.Reg 79/10 s. 50. (2)	CO #003	2015_250511_0005	130

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A) The written plan of care for resident #098, directed staff to put two bed rails up

when the resident was in bed for safety; however, the lift logo located in the resident's closet directed staff to put one bed rail up when the resident was in bed. On an identified date in 2016, the resident was observed in bed with one bed rail up. Staff #150 confirmed they followed the direction from the lift logo in the closet. Staff #101 confirmed the written plan of care was the most current direction and that the lift logo should have been changed.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 007517-16, conducted concurrently during this Resident Quality Inspection.(Inspector #130).

B) The Minimum Data Set Resident Assessment Instrument (MDS RAI) assessment completed for resident #093 on an identified date in 2015, indicated the resident was frequently incontinent of urine and used a pad for containment. The Resident Incontinence Assessment Tool completed on an identified date in 2015, indicated the resident was frequently incontinent and required a "Tena" brief. The document known in the home as the "care plan", indicated the resident was incontinent of bladder and wore a pull up brief. The ADOC confirmed the resident was frequently incontinent and wore a pull-up at the family's request. The plan of care did not provide clear direction to staff related to the management of bladder incontinence.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log #029297-15 , conducted concurrently during this Resident Quality Inspection.(Inspector #130). [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A) The Falls Risk Assessment completed for resident #098 on an identified date in 2016, identified the resident was a high risk for falls; however, the written plan of care reviewed around the same time period identified the resident was at moderate risk for falls. Staff #105 confirmed the written plan of care was not based on the assessed needs of the resident.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 007517-16, conducted concurrently during this Resident Quality Inspection.(Inspector #130). [s. 6. (2)]

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

A) According to the clinical record, resident #200 sustained a fall in 2015, with suspected injury. The resident was assessed by the physician and tests were ordered. A physiotherapy assessment was completed for the resident after the fall and recommendations were made while the tests were pending.

After the PT recommendations were made, a progress note identified staff did not comply with the PT recommendations; the resident expressed ongoing pain to a specific area during care.

The test results were faxed to the home on an identified date and confirmed an injury. A progress note written the day after the test results were received by the home, indicated the resident continued to express pain with movement; the nurse would notify the physician of the results.

A progress note documented two days later, by staff #134, identified resident #200 continued to experience pain; a request was made for direction from physiotherapy or the physician.

A progress note documented the same day, identified that staff again did not comply with the original recommendations made by the PT; the resident had difficulty during the care; it was identified further direction was required from the PT and/or physician.

The progress note documented the following day, identified the physician spoke to resident #200 and agreed that no surgical intervention would be done in relation to their injury.

A progress note documented the same day, identified resident #200 was assisted with care, in a manner that did not comply with the PT's recommendations.

A progress note documented by the Physician several days later (late entry for a previous date), identified that the resident had a specified injury, but was comfortable; the resident and staff had complied with the PT's recommendations and identified the injury would heal on its own; could retest in a few weeks;

however, a review of the plan of care and interviews with staff and PT during the inspection confirmed the resident and staff had not complied with the PT recommendations.

In an interview with the PT on an identified date in 2016, it was confirmed that after their assessment was completed, just after the resident sustained the suspected injury, a follow up assessment was not completed until a number of weeks later and no changes or revisions were made to resident #200's care plan. It was confirmed a falls care plan was not created until a number of months after the injury.

In an interview with the PT on an identified date in 2016, it was confirmed their recommendations were not clearly communicated to the interdisciplinary team as resident #200's care plan was not updated or revised and staff continued to provide care to the resident, despite the earliest recommendations made after the injury.

In an interview with the DOC, it was confirmed staff and others involved in the different aspects of care of the resident did not collaborate with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complement each other.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 000918-15, conducted concurrently during this Resident Quality Inspection. (Inspector #583). [s. 6. (4) (a)]

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

A) The plan of care for resident #098 directed staff to put two bed rails up when in bed for safety; have a specific intervention in place at all times and another intervention in place at specified times. A Critical Incident submission and the DOC confirmed that on an identified date in 2015, the resident fell and sustained an injury; the resident did not have a a specified intervention in place at all times, as specified in the plan of care.

On another identified date in 2016, the same resident was observed; staff #101 confirmed the resident did not have at least three of the required interventions in place, as specified in the plan of care.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 007517-16, conducted concurrently during this Resident Quality Inspection. (Inspector #130).

B) On an identified date in 2016, resident #404 was observed at a specified time. The resident had been taken to their room by staff; staff #162 confirmed that the resident had been repositioned but not toileted.

A review of the resident's written plan of care indicated that the resident was to be toileted at specified times to prevent incontinent episodes. It was observed by the Inspector and confirmed by staff #162, that resident #404 was not toileted at the specified time.

It was confirmed by staff #162 and observed by the Inspector on an identified date in 2016, that the care set out in the plan of care was not provided to resident #404 as specified in the plan. (Inspector #508).

C) Resident #402 was identified as a risk for falls and had interventions in place to minimize the risk for falls. The resident was to have a specified intervention in place at specific times.

On an identified date in 2016, it was observed by the Inspector that resident #402 had the intervention in place; however, the intervention had not been applied to ensure their safety, as required.

It was confirmed by staff #102 that the resident's safety intervention was not applied to the resident properly as specified in the resident's plan of care. (Inspector #508).

D) A test completed on an identified date in 2015, identified resident #200 had an injury of unknown cause. Investigation notes completed by the DOC on an identified date in 2015, identified staff #212 responded to the call bell and found resident #200 standing by their bed losing their balance. It was documented that staff #212 supported resident #200 to prevent them from falling and twisted the resident to sit them on their bed. Staff #212 then assisted resident #200 to the washroom. The progress notes completed by staff #212, on an identified date in 2015, indicated resident #200 was found to have a minor injury to a specified area and expressed pain to another area, after the resident was toileted.

A review of the plan of care identified resident #200 required extensive assistance from two staff members for toileting and two staff members for side by side transfers. In an interview with the DOC on an identified date in 2016, it was confirmed that the resident was toileted and transferred by one staff member on the identified date and not two staff as specified in the plan of care.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 000918-15, conducted concurrently during this Resident Quality Inspection. (Inspector #583). [s. 6. (7)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or when care set out in the plan was no longer necessary.

A) The Falls Risk Assessment completed for resident #098 on an identified date in 2016, identified the resident was at risk for falls; however, the written plan of care reviewed approximately one month later, identified the resident was at moderate risk for falls. Staff #105 confirmed the written plan of care had not been updated when the resident's care needs changed.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 007517-16, conducted concurrently during this Resident Quality Inspection. (Inspector #130).

B) Resident #109 started to exhibit symptoms of an infection in 2015. The resident was treated by nursing staff until the physician assessed the resident approximately one week later. The physician diagnosed the resident with a specific diagnosis and ordered a medication.

A review of the resident's plan of care for the same time period in 2015, indicated that the resident's plan had not been reviewed or revised to identify that the resident had an infection.

It was confirmed by staff #109 during an interview on March 17, 2016, that the plan of care for resident #109 had not been reviewed or revised when the resident's care needs changed. (Inspector #508).

C) The MDS RAI assessment completed for resident #093 on an identified date in 2015, indicated the resident was coded a four, indicating the resident had inadequate control of their bowel all or most of the time. This showed a decline in bowel continence since the previous MDS RAI assessment, which indicated the resident was coded a three; frequently incontinent of bowel, two to three times a week. The document known in the home as the care plan, indicated staff were to monitor the resident's bowel continence with the goal that the resident would remain continent of bowels. The toileting plan indicated the resident had potential to restore function to maximum self-sufficiency for the physical process of toileting. The ADOC confirmed that the resident was incontinent, did not have the potential to restore function to maximum self sufficiency and that the written care plan for bowel continence and toileting was not up to date.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 029297-15, conducted concurrently during this Resident Quality Inspection.(Inspector #130).

D) According to documentation in resident #093's clinical record on an identified date in 2015, an intervention was put in place to prevent another resident from entering their room. On a later date in 2015, registered staff documented in a progress note that the resident kept removing the intervention and threw it away; hence staff took it away. The document known in the home as the care plan was not updated to reflect this information until a specified date in 2016. This information was confirmed by the Staff Development Coordinator.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 029297-15, conducted concurrently during this Resident Quality Inspection. (Inspector #130).

E) A physiotherapy assessment was completed for resident #200 on an identified date in 2015, due to pain. It was identified in the assessment that results of a test was pending. The assessment documented in the progress notes identified specific recommendations. A review of the plan of care identified that these recommendations were not added to resident #200's plan of care or the "kardex", which was used to direct the resident's care. In a progress note documented after the physiotherapy assessment, it was documented that resident #200 was having pain while they received care. A progress note documented several days later, by staff #134, identified resident #200 continued to experience pain; a request was made for direction from physiotherapy or the physician. In an interview with the PT

on an identified date in 2016, it was confirmed that they did not update resident #200's plan of care after they assessed the resident on an identified date in 2015. The care plan was not updated when the resident's care needs changed.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 000918-15, conducted concurrently during this Resident Quality Inspection. (Inspector #583). [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001,002

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

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

WN #2: 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 did not ensure that every resident was protected from abuse by anyone.

A) On an identified date in 2014, resident #089 was pushed by resident #090, during an altercation, which resulted in injury to resident #089. Both residents were cognitively impaired and had a history of responsive behaviours towards each other. The DOC confirmed resident #089 was not protected from abuse by resident #090.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 000341-14, conducted concurrently during this Resident Quality Inspection.(Inspector #130).

B) A review of the progress noted on an identified date in 2015, identified resident #201 had an unwitnessed fall. The resident was found by staff #162, vomiting on the floor next to their doorway. Resident #201 was then assessed by staff #121 and found to have an elevated vital sign and continued vomiting. The resident was placed in their bed using a lift with three staff. Staff #121's assessment included a documented heart rate, pulse rate and respiratory rate.

A review of the Neurological Sign: Head Injury Routine Policy (08-01-27) identified a head injury routine was to be completed for residents who had an unwitnessed fall who were confused or diagnosed with dementia. The procedure directed registered staff to:
- Immediately assess resident's neurological signs using the "Neurological Assessment Record"
- Continue with the head injury routine, assessing neurological vitals as follows until further direction from physician:
Every 15 minutes x 8 for 2 hours, then if stable
Every 30 minutes x 4 for 2 hours, then if stable

Every 1 hour x 4 for 4 hours, then if stable
Every 4 hours x4 for 16 hours.
- Continue to assess for any untoward symptom such as, nausea and vomiting and if any untoward effects are shown notify physician immediately and prepare to send the resident to hospital.

In an interview with staff #121 in 2016, it was confirmed that a neurological assessment including level of consciousness, pupil response and ability to move was not completed when resident #201 was found to have an unwitnessed fall. Resident #201 had untoward symptoms of vomiting; the physician was not notified and the resident was not prepared to be sent to hospital. No other assessments of resident #201 were completed by staff #121 during their shift.

A review of the progress note on an identified date in 2016, documented at 2143 hours by staff #101 identified the next assessment of resident #201, was at supper time when medications were provided and did not contain a neurological assessment or vitals. The next assessment was completed by staff #101 at 2030 hours, at which time it was documented that resident #201 was found to be unresponsive to verbal or tactile stimuli. The resident's code status was identified to be a level four, 911 was called and the resident was transferred to hospital.

In a progress note written on an identified date in 2015, at 1518 hours, it was documented that the DOC spoke to the Registered Nurse in the Intensive Care Unit (ICU) where resident #201 was transferred. It was shared with the DOC that resident #201 had a serious injury.

In a progress note days later in 2015, it was documented that the Clinical Coordinator spoke to the charge nurse in the Intensive Care Unit (ICU), where resident #201 was transferred. It was shared with the Clinical Coordinator that resident #201 passed away as a result of their injury.

In an interview with the DOC in 2016, it was confirmed that the home neglected to provide resident #201 with the care required for their health and well-being. It was confirmed that there was a pattern of inaction that included no neurological assessments of the resident following the "Neurological Sign: Head Injury Routine Policy" and a time period of approximately three hours passed before resident #201 received a second assessment which jeopardized the health and well-being of the resident.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 001979-15, conducted concurrently during this Resident Quality Inspection. (Inspector #583).

C) A review of the progress notes documented on an identified date in 2015, identified resident #200 was found to have a minor injury to a specified area and pain to another area, from an unknown injury during the night. The resident was assessed by staff #132 and the incident was communicated to the registered nursing staff on day shift.

A review of the next progress note documented on the day shift by staff #109, identified resident #200 reported to the Personal Support Workers (PSW) that they had a fall during the night. The resident had a specific medical history that resulted in a specified deficit. The PSWs reported to staff #109 that the resident could not fully weight bear.

In an interview with the DOC in 2016, it was confirmed a post fall assessment was not completed after resident #200 reported they had a fall and at the time of the fall the home did not have a Falls Policy in place.

The progress note documented at 1521 hours noted the resident was assessed by the physician and a test was ordered to rule out injury.

The progress note documented later, identified resident #200 had ongoing pain with movement.

A physiotherapy assessment was completed for resident #200 after the fall for complaints of pain. The assessment documented in the progress notes included specific interventions and indicated the PT would continue to monitor.

In an interview with the PT in 2016, it was confirmed their recommendations were not clearly communicated to the interdisciplinary team as resident #200's care plan was not updated or revised and staff did not comply with the recommendations made.

The progress note dated the same date as the PT assessment in 2015, provided care in contrast to the recommendations and that the resident expressed ongoing pain to a specific area.

The results of the test were faxed to the home the following day and confirmed the resident had an identified injury. A progress note dated two days after the suspected injury was sustained, identified staff #109 received the test results, the resident had continued pain with movement and that they would notify the physician of the results.

In an interview the DOC in 2016, it was confirmed that the physician was notified of the test results the day after the home received the results. A review of the Notification of Physician Policy (03-03-02) identified the physician should be notified immediately, "If symptoms indicate medical interventions may be necessary, such as xrays, emergency treatment".

The progress note documented four days after the suspected injury occurred, identified the staff transferred resident #200 and did not comply with the PT recommendations when providing care to the resident. It was identified that further direction was required from the PT and/or physician.

The progress note documented five days after the suspected injury occurred identified that the physician spoke to resident #200 and agreed that no surgical intervention would be done in relation to their injury.

The progress note documented the same date, at 2215 hours, identified resident #200 again received care from staff that contrasted the PT's recommendations.

A progress note documented by the physician several days later (late entry for a previous date), identified that the resident had a specified injury, but was comfortable; the resident and staff had complied with the PT's recommendations and identified the injury would heal on its own; could retest in a few weeks; however, a review of the plan of care and interviews with staff and PT during the inspection confirmed the resident and staff had not complied with the PT recommendations.

The progress note documented nearly a week after the incident, identified the resident requested pain medication after being transferred into bed.

In an interview with the PT in 2016, it was confirmed that after their initial assessment, a follow up assessment was not completed until weeks later. It was confirmed that the resident was not assessed for safe positioning and transferring after it was confirmed they had an identified injury and no changes or revisions

were made to resident #200's care plan. It was confirmed a falls care plan was not created until months after the fall with injury.

A review of the plan of care identified a significant change assessment was not completed after resident #200 had a confirmed injury.

In an interview with the DOC in 2016, it was confirmed that the home neglected to provide resident #200 with the care required for their health and well-being. A pattern of inaction was confirmed with the PT and the DOC, that jeopardized the health and well-being of the resident. It included not completing the required assessments needed to determine the resident's care needs, the physician not being notified of resident #200's injury for approximately three days and the lack of collaboration between interdisciplinary team members.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 000918-15, conducted concurrently during this Resident Quality Inspection. (Inspector #583). [s. 19. (1)]

Additional Required Actions:

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

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

WN #3: 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 did not ensure that the home was a safe and secure environment for its residents.

A) On March 30, 2016, the first floor and second floor environment was observed to be unsafe and unsecure for residents. The Administrator and DOC were informed immediately of all unsafe conditions during the inspection. The Administrator was not able to provide any documentation or evidence that resident occupied zones were being inspected for health and safety hazards on a daily basis. According to the maintenance staff, a routine tour through the home was conducted daily at the beginning of the shift and would include general issues encountered on a day to day basis when the home was not undergoing any renovations. No check list or specialized routine was developed for maintenance staff with respect to construction and renovation hazards and issues.

The licensee began extensive renovations in the home in mid-2015. The plan was to construct a new section of building, connect it to the existing building and close down one wing for renovation per floor while leaving two wings occupied by residents. The 2nd floor had one wing closed down and one new wing fully occupied which opened in mid-March 2016. The new wing consisted of a sloped ramp between the new and existing building, a chapel, administrative offices and a hair salon.

1. Next to the hair salon, a bay window was left unsecured. On March 29, 2016 and according to maintenance staff, a construction worker broke a glass panel within the bay window. No board or solid barrier was erected onto the frame to prevent cold air from entering the home or to prevent a resident from squeezing through the frame and out onto the roof. On March 30, 2016, at approximately 1000 hours the Inspector noticed the broken panel and management staff was notified of the unsecured window. The window was left unsecured at time of departure at approximately 1515 hours.

2. The hair salon on the second floor, according to the Administrator, was empty of supplies and furnishings on March 28, 2016. Inspectors #583 and #130 observed residents sitting in the space watching television prior to March 28, 2016. However, on March 29, 2016, boxes of supplies and other items were transferred into the room, including concentrated disinfectant (Barbicide) which was left on top of a counter within the room. On March 30, 2016, a resident was observed sitting in the room unsupervised with access to the disinfectant. The staff did not ensure

that the various supplies were evaluated for safety risks and that they were secured before bringing residents into the room.

3. On a specified date in 2016, at approximately 0945 hours, one wing on the 1st floor was being prepared for closure. Just past the main entry to the building and across the hall from a resident sitting area, the door to the former office area was observed to be wide open and unlocked. The Inspector was able to easily walk through this area and directly into the renovation zone where ceiling tiles had been removed, wires and cabling were hanging down from the ceiling, equipment such as ladders and tools were noted and construction workers. A tarp was hung loosely from the false ceiling down to the floor along the path of travel from the visitor washroom (located next to the former office area), past the nursing office and towards wing two consisting of resident rooms. The tarp was open on either end and the renovation zone was fully accessible and visible from the resident occupied side. Construction workers were seen walking from the former unoccupied offices and into the renovation zone via the openings in the tarp.

4. A resident was sitting in a chair up against the loosely hung tarp directly in front of the nursing office. Two other chairs were placed in this area. Behind the resident, construction workers were erecting a temporary wall made of drywall and metal framing. The sound of a nail gun was heard where a worker was connecting material directly behind and above the resident on the opposite side of the tarp. Registered staff who were sitting inside of the office were immediately informed of the safety risks.

5. The new wing on the 2nd floor was constructed with a gradual slope increasing in height between the hair salon and the administrative offices. Just in front of the administrative office entrance, an uneven area or "hump" was left in place. The hump was approximately 3 feet wide and had a prominent leading edge on one side, facing the entry door. It appeared as if the concrete that was poured in this area was not leveled out and was left in place. Trip and fall concerns for all occupants and visitors were discussed with the Administrator. (Inspector #120). [s. 5.]

Additional Required Actions:

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

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that all staff received training on the home policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities.

A) During this inspection, the 2015 staff education records were reviewed. A review of the sign in sheets for the training on the home's abuse policy indicated that only 134 staff out of 231 had received abuse training.

It was confirmed during an interview with the ADOC on March 30, 2016, that not all staff received training on the home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities.

PLEASE NOTE: This non compliance was identified during a Follow-up Inspection, log# 011649-15, conducted concurrently during this Resident Quality Inspection. (Inspector #508). [s. 76. (4)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 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 instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act.

A) The home's policy Skin Care: General Guidelines, 05-07-20-22-20A, did not contain information that directed staff to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, within 24 hours of the resident's admission; upon any return from hospital; upon any return of the resident from an absence of greater than 24 hours and that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the

registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. The policy also indicated that a "Reassessment of area(s) was to occur at least weekly by Registered staff, Nurse Practitioner or Physician until healed"; however, in accordance with s. 50. (2) (b) (iv), a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, shall be reassessed at least weekly by a member of the registered nursing staff and not the Nurse Practitioner or Physician, if clinically indicated.

The home's policy was not in compliance with all applicable requirements under the Act. This information was confirmed by the ADOC. (Inspector #130)

B) The continence care and bowel management program must, at a minimum, provide for the following: 1. Treatments and interventions to promote continence. 2. Treatments and interventions to prevent constipation, including nutrition and hydration protocols. 3. Toileting programs, including protocols for bowel management. 5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts were negotiated or renegotiated.

A review of the resident Continence Policy, #05-04-13 had not identified the following: treatments and interventions to promote continence, treatments and interventions to prevent constipation, including nutrition and hydration protocols, toileting programs, including protocols for bowel management or an annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts were negotiated or renegotiated.

The DOC confirmed that policy #05-04-13 was the home's current incontinence program and during an interview on March 30, 2016, it was confirmed that the policy was not in compliance with and was not implemented in accordance with all applicable requirements under the Act. (Inspector #508). [s. 8. (1) (a)]

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

A) The home's policy Skin Care: General Guidelines, 05-07-20-22-20A indicated: Any change in skin integrity was to be reported to the charge nurse; Assessment of change was to be completed and documented by a Registered Staff in progress notes, on "Weekly Wound/Skin Assessment Summary" and on 24-hour report; Reassessment of area(s) was to occur at least weekly by Registered Staff, Nurse Practitioner, or Physician until healed.

Resident #097 was admitted to the home an identified date in 2015, with impaired skin integrity to an identified area. According to the clinical record the resident received a weekly skin assessment by a member of the registered nursing staff eight times over a ten month period from 2015 - 2016, during which time they had impaired skin integrity. The ADOC confirmed that registered staff did not consistently complete the weekly skin assessments, as directed in the home's policy. (Inspector #130).

B) On an identified date in 2016, resident #098 sustained a fall which resulted in injury. The resident returned to the home following a brief hospital admission. Staff #105 verified that the resident did not receive a skin assessment by registered staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment and that weekly skin assessments were not completed over a ten day period in 2016, during which time the resident had impaired skin integrity. (Inspector #130).

C) On an identified date in 2016, Inspector #583 observed staff #134 administering a subcutaneous medication to resident #207. Resident #207 was in a public area with their gown pulled up and their undergarments exposed to people walking on the unit. A review of the Nursing Medication Administration Policy (05-02-18) identified, the procedure for the administration of subcutaneous injections included "assure resident's privacy". In an interview with the DOC on March 21, 2016, it was confirmed that the Nursing Medication Administration Policy was not complied with. (Inspector #583).

D) The progress notes recorded on an identified date in 2015, identified resident #200 was found to have a minor injury to an identified area and pain to another area. Resident #200 shared with staff that they had a fall. The physician completed an assessment and ordered a test. The results of that test was faxed to the home on on an identified date and confirmed the resident had an injury. In a progress note the following day, it identified staff #109 received the test results and it was documented they would notify the physician the next day. A review of the

Notification of Physician Policy (03-03-02) identified the physician should be notified immediately, "If symptoms indicate medical interventions may be necessary, such as x-rays, emergency treatment". In an interview the DOC in 2016, it was confirmed that the physician was notified days after the results were known. It was confirmed that the Notification of Physician Policy was not complied with as the physician was not immediately notified of the test results and that a physician assessment was required to determine if medical interventions would have been required.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 000918-15, conducted concurrently during this Resident Quality Inspection.(Inspector #583).

D) A review of the progress noted recorded on an identified date in 2015 and an incident report completed the same date, identified resident #201 had an unwitnessed fall. Staff #162 found resident on the floor near their doorway, vomiting. Resident #201 was assessed by staff #121 and found to have an elevated vital sign and continued vomiting. A review of the plan of care identified resident #200's usual cognitive functions included a deficit in memory, judgment, decision making and thought processes.

A review of the Neurological Sign: Head Injury Routine Policy (08-01-27) identified a head injury routine was to be completed for residents who had an unwitnessed fall who were confused or diagnosed with dementia. The procedure directed registered staff to:

1) Immediately assess resident's neurological sign using the "Neurological Assessment Record"

2) Continue with the head injury routine, assessing neurological vitals as follows until further direction from physician:

Every 15 minutes x 8 for 2 hours, then if stable
Every 30 minutes x 4 for 2 hours, then if stable
Every 1 hour x 4 for 4 hours, then if stable
Every 4 hours x 4 for 16 hours.

3) Continue to assess for any untoward symptom such as, nausea and vomiting and if any untoward effects shown notify physician immediately and prepare to

send the resident to hospital.

In an interview with staff #121 on an identified date in 2016, it was confirmed neurological signs were not completed for resident #200 after their unwitnessed fall. A review of the progress notes and critical incident form showed the physician was not notified and staff #121 confirmed resident #200 was found to have vomited on the initial assessment after their unwitnessed fall. It was confirmed with staff number #121 that the second resident assessment after the initial assessment completed at 1400 hours was completed by staff #101 at 2030 hours when resident was found to be unresponsive.

In an interview with the DOC, it was confirmed that the Neurological Sign: Head Injury Routine Policy was not complied with.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 001979-15, conducted concurrently during this Resident Quality Inspection. (Inspector #583). [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act and complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The home's Resident Abuse Policy, 02-02-04 indicated: "Careful documentation is essential. The following information shall be recorded on the incident report: A description of the situation, the resident response, resident comments, identification of other involved persons, description of any injury and actions taken; When the initial investigation suggests there may be elder mistreatment, the following shall apply if the suspected abuser is: An employee: that employee shall be immediately suspended without pay; when any employee suspects there has

been abuse of a resident, the employee will report the incident or suspicion to the Charge Nurse. The Charge Nurse will initiate a call to the Ministry of Health Performance Improvement and Compliance Branch to report the incident. The DOC or ADOC on call will be notified and will initiate a Critical Incident Report to the Ministry of Health with 24 hours.

A) On an identified date in 2015, staff #114 reported witnessing staff #238, transferring resident #095 via the ceiling lift, with their right hand over the resident's mouth to silence screaming and the left hand operating the remote control of the lift. Staff #114 stated in an interview, they left the room and closed the door without intervening. Documentation confirmed that staff #114 completed treatment for a co-resident, before reporting the incident to the RN on duty. Staff #099 confirmed they were in charge at the time of the incident, confirmed they allowed staff #238 to complete the remainder of their shift, they did not assess the resident and they did not document the incident in the resident's clinical record. This information was confirmed by the DOC.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 011133-15, conducted concurrently during this Resident Quality Inspection.(Inspector #130).

B) According to a Critical Incident submission (CI), on an identified date in 2015, resident #108 wandered into resident #089's room and grabbed onto the co-resident which caused resident #089 to scream. Staff intervened, separated the residents and redirected resident #108 out of the room. It was noted at this time that resident #089 sustained a minor injury due to this incident.

The registered staff on duty informed the ADOC of the incident on the same date the incident occurred; however, the incident was not reported to the Director, as directed in the home's policy until five days after the incident occurred. Documentation and the DOC confirmed during an interview, that the written policy to promote zero tolerance of abuse and neglect of residents was not complied with. (Inspector #508). [s. 20. (1)]

2. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 of the Act to make mandatory reports. This information was confirmed by the Administrator. (Inspector #130). [s. 20. (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 written policy that promotes zero tolerance of abuse and neglect of residents is complied with an contains an explanation of the duty under section 24 of the Act to make mandatory reports, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident's skin condition, including altered skin integrity .

A) Resident #098 had a surgical procedure in 2016, which resulted in impaired skin integrity to an identified area which required treatment over a 10 day period. Staff #105 verified there was no written plan of care in place to manage the potential risks associated with respect to their altered skin integrity.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 007517-16, conducted concurrently during this Resident Quality Inspection.(Inspector #130). [s. 26. (3) 15.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a plan of care is based on, at a minimum, interdisciplinary assessment with respect to the resident's skin condition, including altered skin integrity, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when they assisted residents.

A) The Administrator and the DOC confirmed in 2016, resident #095 was transferred via a mechanical lift, with only one staff supervising and operating the lift. They confirmed it was the expectation that two staff were present for all mechanical lift transfers.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 011133-15, conducted concurrently during this Resident Quality Inspection.(Inspector #130). [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #9: 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 failed to ensure that the resident who was incontinent received an assessment using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident was required.

A) Resident #105 was frequently incontinent of bowel and bladder during a time period in 2015. Later in 2015, the resident's incontinence for bladder deteriorated and the resident was totally incontinent of their bladder.

A review of the resident's clinical record indicated that when the resident's incontinence status worsened in 2015, an assessment had not been conducted at that time.

It was confirmed during an interview with the Registered Nurse in 2016, that when the resident's incontinence status deteriorated an assessment had not been conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. (Inspector #508).

B) Resident #111 was occasionally incontinent of their bladder during a time period in 2015, and then declined to being frequently incontinent later in 2015. A review of the resident's clinical record indicated that an assessment had not been conducted when the resident's continence level declined.

It was confirmed by the Registered Nurse (RN) during an interview that when required, the resident who was incontinent did not receive an assessment using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. (Inspector #508).

C) The MDS RAI assessment completed for resident #093 on an identified date in 2015, indicated the resident was coded a four, which indicated the resident had inadequate control of bowel all or most of the time. This showed a worsening in bowel continence from the previous MDS RAI assessment, which indicated the resident was coded a three; frequently incontinent of bowel, two to three times a week. The Staff Development Coordinator confirmed that a Resident Incontinence Assessment Tool was not completed when there was a change in the resident's continence.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 029297-15, conducted concurrently during this Resident Quality Inspection.(Inspector #130). [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who is incontinent receives an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident is required, to be implemented voluntarily.

WN #10: 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 failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A) Resident #400 sustained an injury on an identified date in 2015, while being pushed by staff #123, in their wheelchair. The resident's body part hit the door

frame of the resident's room door when entering the room.

A review of the resident's clinical record indicated that the resident's pain was assessed on at least three occasions following the incident due to the resident's complaints of pain to an affected area. It was also identified that the affected area showed signs of injury hours after the incident.

Resident #400 continued to complain of pain and a test confirmed that the resident had sustained an injury. The resident was sent to hospital for further assessment and returned to the home the same day with a treatment in place to the affected area.
Days later the physician documented in the resident's clinical record that the resident had inadequate pain control and ordered an increase in the resident's regular analgesic, to manage the resident's pain.

A review of the resident's clinical record indicated that a pain assessment using a clinically appropriate instrument had not been conducted after the injury occurred. A pain assessment was not conducted again until a least a week later.

It was confirmed by the DOC during an interview that when the resident's pain was not relieved by initial interventions, the resident was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

PLEASE NOTE: This area of non-compliance was identified during a Critical Incident (CI) inspection, log #033591-15, conducted concurrently during the RQI. (Inspector #508).

B) It was reported to staff in 2013, by the resident's family member, that while the family member was visiting resident #407, the resident was exhibiting signs of pain to a specific area and the family member requested that staff assess the resident.

The staff member followed up with the concern, observed the affected area and documented in the resident's clinical record that the affected area showed signs of injury and pain for the resident.

The resident was transferred to hospital for a test, which confirmed the suspected injury.

A review of the resident's clinical record indicated that the resident was exhibiting

signs of pain which was reported to the staff on an identified date in 2013. A pain assessment using a clinically appropriate assessment instrument specifically designed for this purpose was not conducted until two days later.

It was confirmed by the DOC during an interview that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

PLEASE NOTE: This area of non-compliance was identified during a Critical Incident (CIS) inspection, log #023727-15, conducted concurrently during the RQI. (Inspector #508). [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 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, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that written approaches to care, including assessments and identification of behavioural triggers that may result in responsive behaviours were developed to meet the needs of residents with responsive behaviours.

A review of resident #107 MDS RAI coding for physical functioning and structural problems documented in 2015, identified the resident had a decline in function and required extensive assistance from two people for dressing. A review of the progress notes over a one month period in 2015, identified resident #107 frequently refused help with Activities of Daily Living (ADL) including assistance dressing and it was documented that the resident was observed wandering at night

in day clothes. In an interview with staff #116 and #144 it was shared resident #107 had responsive behaviours that were triggered when staff provided assistance with ADL's. Staff shared that resident #107's friend came into the home daily to assist with dressing the resident and provided assistance with ADL's. It was shared that when the friend provided care the resident only required limited assistance from one person.

In an interview with the Staff Development Coordinator it was confirmed that the plan of care did not include an assessment and did not identify behavioral triggers for resident #107's responsive behaviours related to assistance with dressing. The plan of care did not contain a dressing focus, did not identify the level of assistance the resident required and did not identify that resident #107's friend regularly provided care as an intervention to help manage the resident's responsive behaviours. It was confirmed with the Staff Development Coordinator that the home's expectation was that the resident should have a dressing focused care plan. (Inspector #583). [s. 53. (1) 1.]

2. The licensee failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours where possible.

A) According to the clinical record resident #091, exhibited responsive behaviours towards staff and co-residents. Staff #098 confirmed the resident demonstrated the responsive behaviours; however, there was no written plan of care put in place to identify the triggers for the responsive behaviour nor any strategies to manage the risks associated with these behaviours.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 033351-15, conducted concurrently during this Resident Quality Inspection.(Inspector #130). [s. 53. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that written approaches to care, including assessments and identification of behavioural triggers that may result in responsive behaviours are developed to meet the needs of residents with responsive behaviours and that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours where possible, 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. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

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 failed to ensure that the advice of the Residents' Council was sought out in the development and carrying out of the satisfaction survey, and in acting on its results.

During an interview with a representative from the Residents' Council, it was identified that they were not familiar with the home's annual survey. A review of the 2015 Residents' Council minutes also indicated that that the annual survey had not been discussed with the Council.

It was confirmed by the Program Manager during an interview on March 30, 2016, that they did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. (Inspector #508). [s. 85. (3)]

2. The licensee failed to ensure that they documented and made available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

A review of the 2015 Residents' Council minutes indicated that there were no discussions held with the Residents' Council regarding the results of the satisfaction survey.

This information was confirmed by the Program Manager during an interview on March 30, 2016. (Inspector #508). [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 advice of the Residents' Council is sought out in the development and carrying out of the satisfaction survey, in acting on its results and to ensure that they 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, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (3) The licensee shall ensure that the home's mechanical ventilation systems are functioning at all times except when the home is operating on power from an emergency generator. O. Reg. 79/10, s. 90 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the home's mechanical ventilation systems were functioning at all times except when the home was operating on power from an emergency generator.

The home's ventilation system which was also connected to their heating system for their main dining room was not functional on March 14, 2016. According to the Administrator, the main dining room was not occupied for several months while repairs and changes were made within the room. The heating/ventilation system for the dining room was also disconnected and reconnected to a new system. Residents were relocated from the main floor activity room back to the dining room for their meals on March 14, 2016. A resident contacted the Ministry action line to report that it was very cold in the dining room on the same date. Ministry Inspectors who were working in the building on the same date also noted the cool air temperatures. The Administrator responded on that date by installing some portable heaters in the dining room however the room was quite large and all residents did not benefit from the heat that the portable units were able to generate. According to the Administrator, the contracted service who was responsible for connecting the heating and ventilation system to the new unit forgot

to turn on a switch. As a result, no ventilation or heat was generated. The system was operational by March 15, 2016.

At the time of inspection, on March 30, 2016, in order to verify whether ventilation and heat were functional, air temperatures were taken and fresh air supply vents were monitored over the lunch time meal. Air temperatures were measured with a hygrometer for over 20 minutes on the opposite side of the room across from the servery. The temperature was 23C (Celcius), however the thermostat, which was located in the warmest part of the dining room (within the servery with the steam tables) indicated 24.5C. No ventilation could be felt or heard running over the course of the lunch hour. The dining room was very stuffy and humid. The steam tables in the room contributed to the humidity in the room. Confirmation was requested from the Environmental Services Supervisor (ESS) that the system was in fact operational. After conferring with the project contractor, the ESS reported that when the new system was connected on March 14, 2016, the heated fresh air component was not programmed to turn on unless the thermostat dipped below a set point of 23.5C. In addition, the percentage of the fresh air supply was set at 20% which provided only 2 air changes per hour instead of the 8 the home used to have. Discussions were held with the Administrator and ESS that the lack of adequate tempered fresh air and exhaust, the increase in humidity and carbon dioxide levels within an occupied room would create uncomfortable conditions for residents. Further, the licensee did not have any records for air temperature monitoring in any part of the building on weekends in 2016 and did not have anyone take temperatures between March 2 and March 14, 2016 when a maintenance person was not available. (Inspector #120). [s. 90. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that the home's mechanical ventilation systems are functioning at all times except when the home is operating on power from an emergency generator, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee did not comply with the conditions to which the licence was subject.

The Long-Term Care Home Service Accountability Agreement (LSSA) with the Local Health Integration Network (LHIN), under the Local Health Systems Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument -Minimum Data Set) system. Each resident's care and service needs shall be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the Assessment Reference Date (ARD) of the previous assessment and will ensure that RAI-MDS tools are used correctly to produce an accurate assessment of the Health Care Service Provider's (HSP) residents (RAI-MDS Data) – 8.1(c)(ii)

A) The home did not meet the criteria for coding bedfast for resident #098 and did not use the RAI-MDS tool correctly to produce an accurate assessment of the Health Care Service Provider's (HSP) residents (RAI-MDS Data) – 8.1(c)(ii):

Staff #105 confirmed that resident #096 was coded as bedfast during the Quarterly review assessments completed on an identified date in 2015 and in 2016. The resident was observed up ion two identified dates in 2016, and stated in an interview that they were up most of the day and go back to bed whenever they choose. Staff #105 was interviewed and confirmed the resident was not bedfast up

to 22 hours on four out of seven days during the observation period.

The assessor should not have coded bedfast on the assessments and in doing so, the licensee did not use the RAI-MDS tool correctly to produce an accurate assessment of the resident. (Inspector #130)

B) Progress notes indicated resident #093, exhibited a specified responsive behaviour towards resident #092, on two identified dates in 2015. Although the MDS RAI Quarterly Review Assessment completed on a later date in 2015, indicated the resident did not exhibit the responsive behaviour during the seven day assessment period; staff did not complete a RAP (Resident Assessment Protocol) to address the episodes of responsive behavioiur, which had occurred since the previous assessment.

The Staff Development Coordinator confirmed there should have been a non triggered RAP to address the responsive behaviours, to further develop the plan of care. The RAI-MDS tool was not correctly used to produce an accurate assessment of the resident.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log #029297-15 , conducted concurrently during this Resident Quality Inspection.(Inspector #130).

C) On two identified dates in 2014, resident #089 and resident #090 were involved in altercations, which resulted in an injury to resident #089. Resident #089 was admitted to the home in 2014, and progress notes reviewed from that time period, confirmed the resident demonstrated repeated responsive behavioiurs towards resident #090. The Quarterly MDS RAI Assessment completed on an identified date in 2014, indicated there had been no responsive behaviours of that nature observed during the seven day assessment period; however, the Staff Development Coordinator confirmed that staff should have completed a non triggered RAP to address the episodes of responsive behaviour which had occurred since the Full Admission Assessment, completed in 2014.

The RAI-MDS tool was not correctly used to produce an accurate assessment of the resident.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 000341-14, conducted concurrently during this Resident Quality

Inspection.(Inspector #130). [s. 101. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee complies with the conditions to which the licence is subject, to be implemented voluntarily.

WN #15: 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).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of an incident in the home no later than one business day after the occurrence of the incident, followed by the report required in subsection (4).

A) On an identified date in 2013, a family member had reported to staff that resident #407, who was cognitively impaired had pain and possibly injury to an affected area.. Registered staff assessed the resident and a requisition was completed to obtain a test.

The next day, the test confirmed that the resident had an injury to the affected area and was transferred to hospital for further assessment and treatment and then returned to the home the same day with a diagnosis of a specific injury.

The DOC, ADOC and the CIS report confirmed the incident was not reported to the Director as required.

PLEASE NOTE: This area of non-compliance was identified during a Critical Incident (CI) inspection, log# 023727-15, conducted concurrently with the RQI. (Inspector #508). [s. 107. (3) 4.]

2. The licensee failed to ensure that a report was made in writing to the Director that set out the following with respect to the incident that included, 3.(v) the outcome or current status of the individual or individuals who were involved in the incident.

The home submitted a CIS report to the Director in 2013, which involved a cognitively impaired resident who had sustained an injury of unknown origin. The report had indicated that a meeting was scheduled with the family, the physician, the management and the staff to discuss the incident as it was unclear at the time how the resident sustained the injury.

After the report had been submitted to the Director, the home was asked to update the CIS to include the outcome of this meeting including the status of the resident. The home did not respond to this request and the CIS had not been updated.

It was confirmed by the DOC during an interview, that the CIS had not been updated as requested by the Director.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection, log# 023727-15 conducted concurrently during the RQI. (Inspector #508). [s. 107. (4) 3. v.]

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 Director is informed of an incident in the home no later than one business day after the occurrence of the incident, followed by the report required in subsection (4)and to ensure that a report is made in writing to the Director that sets out the following with respect to the incident that includes, 3.(v) the outcome or current status of the individual or individuals who are involved in the incident, to be implemented voluntarily.

WN #16: 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 failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

A) In 2016, a family member was in the home visiting resident #401 when they observed that the wheelchair that the resident was sitting in was visibly soiled. The family member reported this to staff and to the home's Administrator.

Staff #075 had been directed by the Administrator to follow up on this concern the following day. Staff #075 confirmed that the resident's wheelchair was heavily soiled and required a "deep clean", which staff #075 did that day.

It was confirmed during an interview with staff #075, that the resident's wheelchair had not been kept clean.

PLEASE NOTE: This area of non-compliance was identified related to complaint inspection, log #005213-16, which was conducted concurrently during the Resident Quality Inspection. (Inspector #508). [s. 15. (2) (a)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee failed to ensure that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of residents.

A) In 2016, a family member was in the home to visit resident #401. The resident who was cognitively impaired attempted to clear their nose in their hands. The family member then approached staff to request tissues for resident #401 to clear their nose.

Staff told the resident's family member that they could not provide any as there were no tissues available in the entire facility. The staff then gave the family member a face cloth to use.

Boxes of tissue were observed by the Inspector in a nursing storage area in the basement on March 30, 2016. The DOC confirmed that tissues were available but only given out upon request and that only the Nursing Managers had access to this storage area.

During an interview with the Administrator, they told the Inspector that the home did not provide tissues to the residents, only for the nursing stations. The DOC indicated that tissues were available but only given out upon request.

It was confirmed by the DOC and the Administrator that supplies, equipment and devices were not readily available at the home to meet the nursing and personal care needs of residents.

PLEASE NOTE: This area of non-compliance was identified during a complaint inspection, log #005213-16, conducted concurrently during the RQI. (Inspector #508). [s. 44.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, (a) contained procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected; (e) identified the training and retraining requirements for all staff, including, (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and (ii) situations that may lead to abuse and neglect and how to avoid such situations.

A) During this inspection the home's Resident Abuse policy #02-02-04, was reviewed and it was identified that it did not include all of the requirements, specifically related to procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected and did not identify the abuse training and retraining requirements for all staff.

The DOC confirmed during an interview on March 30, 2016, that policy #02-02-04 was the home's current abuse policy and that it did not contain procedures and interventions to assist and support residents who had been abused or neglected or allegedly abused or neglected and it did not identify the abuse training and retraining requirements for all staff. (Inspector #508). [s. 96. (a)]

Issued on this 29 day of June 2016 (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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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119 King Street West, 11th Floor
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : GILLIAN TRACEY (130) - (A1)

Inspection No. / No de l'inspection : 2016_323130_0007 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 006418-16 (A1)

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

Report Date(s) / Date(s) du Rapport : Jun 28, 2016;(A1)

Licensee / Titulaire de permis : HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3

LTC Home / Foyer de SLD : HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Rosemary Okimi

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 HERITAGE GREEN NURSING HOME, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_312503_0007, 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 for all residents including residents #098 , #200 , #402 and #404, is provided to the residents as specified in their plans; including but not limited to: fall prevention interventions and strategies to mitigate risks to residents, safe lift and transfers techniques utilized by staff, and established toileting routines.

The home shall educate the staff about ensuring the care plan is reviewed according to their policies prior to the provision of care and that examples are provided of what harm can happen to residents when staff fail to provide the care accordingly.

The home shall establish an auditing process to ensure ongoing compliance.

Grounds / Motifs :

1. The licensee failed to ensure that care was provided as per the plan of care.

An xray completed on January 9, 2015, identified resident #200 had a fracture of their right femur of unknown cause. Investigation notes completed by the Director of Care (DOC) on January 13, 2015, identified staff #212 responded to call bell and found resident #200 standing by their bed losing their balance on January 7, 2015. It was documented that staff #212 supported resident #200 to prevent them from falling and twisted the resident to sit them on their bed. Staff #212 then assisted resident #200 to the washroom. The progress notes dated January 7, 2015, identified resident #200 was found to have a small abrasion with bleeding on their right ankle and right hip pain by staff #212 after the resident was toileted.

A review of the plan of care identified resident #200 required extensive assistance from two staff members for toileting and two staff members for side by side transfers. In an interview with the DOC on March 30, 2016, it was confirmed that the resident was toileted and transferred by one staff member on January 7, 2015 and care was not provided as per the plan of care. (#583)

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 000918-15, conducted concurrently during this Resident Quality Inspection. (583)

(A1)
2. The Order is made based upon the application of the factors of severity (2), scope (3) and compliance history (4), in keeping with s.6 (7) of the Act, in respect of the potential for harm to residents #098 , #200 , #402 and #404, the scope of four widespread incidents, and the Licensee's history of non-compliance (CO) on April 29, 2015, related to snack and meal service.

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

A) The written plan of care for resident #098, directed staff to put two bed rails up when the resident was in bed for safety; however, the lift logo located in the resident's closet directed staff to put one bed rail up when the resident was in bed. On an identified date in 2016, the resident was observed in bed with one bed rail up. Staff #150 confirmed they followed the direction from the lift logo in the closet. Staff #101 confirmed the written plan of care was the most current direction and that the lift logo should have been changed.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection,log# 007517-16, conducted concurrently during this Resident Quality Inspection. (Inspector #130).

B) The Minimum Data Set Resident Assessment Instrument (MDS RAI) assessment completed for resident #093 on an identified date in 2015, indicated the resident was frequently incontinent of urine and used a pad for containment. The Resident Incontinence Assessment Tool completed on an identified date in 2015, indicated the resident was frequently incontinent and required a "Tena" brief. The document known in the home as the "care plan", indicated the resident was incontinent of bladder and wore a pull up brief. The ADOC confirmed the resident was frequently incontinent and wore a pull-up at the family's request. The plan of care did not provide clear direction to staff
related to the management of bladder incontinence.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection,log #029297-15, conducted concurrently during this Resident Quality Inspection. (Inspector #130). (508)

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

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

Sep 30, 2016(A1)

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all residents, including residents #093, #098 and #109 are reassessed and their plans of care reviewed and revised at least every six months and at any other time when a goal is met, when the resident's care needs change or when care set out in the plan of care is no longer necessary, specifically, but not limited to: falls prevention strategies to mitigate risk to the resident, infection control and prevention strategies to identify and reduce the incidence of infection and bowel management interventions and toileting activities.

The licensee shall provide education to all front line staff regarding the plan of care, expectations for use and the requirement to ensure that the plan is up to date and accurate at all times.

This education shall provide direction to each job position regarding the responsibilities in ensuring the plan of care is kept up to date and reviewed and revised as required.

The licensee shall conduct auditing activities of resident's plans of care at a frequency and schedule as they determine to ensure that the plans are reviewed and revised at least every six months and at any other time when a goal is met, when the care needs change or when care set out in the plan of care is no longer necessary.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (3) and compliance history (4), in keeping with s.6 (10) (b) of the Act, in respect to the potential for harm to residents #093, #098 and #109, the scope of four widespread incidents, and the Licensee's history of non-compliance (CO) January 25, 2013, during Dietary Follow-up, related to nutritional assessments.

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or when care set out in the plan was no longer necessary.

A) The Falls Risk Assessment completed for resident #098 on an identified date in 2016, identified the resident was at risk for falls; however, the written plan of care

reviewed approximately one month later, identified the resident was at moderate risk for falls. Staff #105 confirmed the written plan of care had not been updated when the resident's care needs changed.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 007517-16, conducted concurrently during this Resident Quality Inspection. (Inspector #130).

B) Resident #109 started to exhibit symptoms of an infection in 2015. The resident was treated by nursing staff until the physician assessed the resident approximately one week later. The physician diagnosed the resident with a specific diagnosis and ordered a medication.

A review of the resident's plan of care for the same time period in 2015, indicated that the resident's plan had not been reviewed or revised to identify that the resident had an infection.

It was confirmed by staff #109 during an interview on March 17, 2016, that the plan of care for resident #109 had not been reviewed or revised when the resident's care needs changed. (Inspector #508).

C) The MDS RAI assessment completed for resident #093 on an identified date in 2015, indicated the resident was coded a four, indicating the resident had inadequate control of their bowel all or most of the time. This showed a decline in bowel continence since the previous MDS RAI assessment, which indicated the resident was coded a three; frequently incontinent of bowel, two to three times a week. The document known in the home as the care plan, indicated staff were to monitor the resident's bowel continence with the goal that the resident would remain continent of bowels. The toileting plan indicated the resident had potential to restore function to maximum self-sufficiency for the physical process of toileting. The ADOC confirmed that the resident was incontinent, did not have the potential to restore function to maximum self sufficiency and that the written care plan for bowel continence and toileting was not up to date.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 029297-15, conducted concurrently during this Resident Quality Inspection.(Inspector #130).

D) According to documentation in resident #093's clinical record on an identified date in 2015, an intervention was put in place to prevent another resident from entering their room. On a later date in 2015, registered staff documented in a progress note that the resident kept removing the intervention and threw it away; hence staff took it away. The document known in the home as the care plan was not updated to reflect this information until a specified date in 2016. This information was confirmed by the Staff Development Coordinator.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 029297-15, conducted concurrently during this Resident Quality Inspection. (Inspector #130).

E) A physiotherapy assessment was completed for resident #200 on an identified date in 2015, due to pain. It was identified in the assessment that results of a test was pending. The assessment documented in the progress notes identified specific recommendations. A review of the plan of care identified that these recommendations were not added to resident #200's plan of care or the "kardex", which was used to direct the resident's care. In a progress note documented after the physiotherapy assessment, it was documented that resident #200 was having pain while they received care. A progress note documented several days later, by staff #134, identified resident #200 continued to experience pain; a request was made for direction from physiotherapy or the physician. In an interview with the PT on an identified date in 2016, it was confirmed that they did not update resident #200's plan of care after they assessed the resident on an identified date in 2015. The care plan was not updated when the resident's care needs changed.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 000918-15, conducted concurrently during this Resident Quality Inspection. (Inspector #583). [s. 6. (10) (b)] (130)

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

Sep 30, 2016(A1)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

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 prepare, submit and implement a plan to ensure that all residents, including resident #089, are protected from abuse by anyone and to ensure that all residents, including resident #200, are not neglected by the licensee or staff.

The plan shall include but not be limited to the following:

1. Mandatory re-education for all staff on abuse.
2. Education for all relevant staff on the home's Falls Management Program.
3. Education for all relevant staff on responsive behaviours.
4. Quality monitoring activities to ensure ongoing compliance with the home's abuse policy, Falls Management Program and responsive behaviours policy.

The plan shall be submitted to Gillian.Tracey@ontario.ca no later than end of business day on May 15, 2016.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (2) and compliance history (2), in keeping with s.19 (1) of the Regulation, in respect of the actual harm that residents #089 and #200 experienced, the scope of a pattern of two incidents, and the Licensee's history of previous non-compliance, unrelated.

The licensee did not ensure that every resident was protected from abuse by anyone.

A) On an identified date in 2014, resident #089 was pushed by resident #090, during an altercation, which resulted in injury to resident #089. Both residents were cognitively impaired and had a history of responsive behaviours towards each other. The DOC confirmed resident #089 was not protected from abuse by resident #090.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 000341-14, conducted concurrently during this Resident Quality Inspection.(Inspector #130).

B) A review of the progress noted on an identified date in 2015, identified resident #201 had an unwitnessed fall. The resident was found by staff #162, vomiting on the floor next to their doorway. Resident #201 was then assessed by staff #121 and found to have an elevated vital sign and continued vomiting. The resident was placed in their bed using a lift with three staff. Staff #121's assessment included a documented heart rate, pulse rate and respiratory rate.

A review of the Neurological Sign: Head Injury Routine Policy (08-01-27) identified a head injury routine was to be completed for residents who had an unwitnessed fall who were confused or diagnosed with dementia. The procedure directed registered staff to:
- Immediately assess resident's neurological signs using the "Neurological Assessment Record"
- Continue with the head injury routine, assessing neurological vitals as follows until further direction from physician:
Every 15 minutes x 8 for 2 hours, then if stable
Every 30 minutes x 4 for 2 hours, then if stable
Every 1 hour x 4 for 4 hours, then if stable
Every 4 hours x 4 for 16 hours.
- Continue to assess for any untoward symptom such as, nausea and vomiting and if any untoward effects are shown notify physician immediately and prepare to send the resident to hospital.

In an interview with staff #121 in 2016, it was confirmed that a neurological assessment including level of consciousness, pupil response and ability to move was

not completed when resident #201 was found to have an unwitnessed fall. Resident #201 had untoward symptoms of vomiting; the physician was not notified and the resident was not prepared to be sent to hospital. No other assessments of resident #201 were completed by staff #121 during their shift.

A review of the progress note on an identified date in 2016, documented at 2143 hours by staff #101 identified the next assessment of resident #201, was at supper time when medications were provided and did not contain a neurological assessment or vitals. The next assessment was completed by staff #101 at 2030 hours, at which time it was documented that resident #201 was found to be unresponsive to verbal or tactile stimuli. The resident's code status was identified to be a level four, 911 was called and the resident was transferred to hospital.

In a progress note written on an identified date in 2015, at 1518 hours, it was documented that the DOC spoke to the Registered Nurse in the Intensive Care Unit (ICU) where resident #201 was transferred. It was shared with the DOC that resident #201 had a serious injury.

In a progress note days later in 2015, it was documented that the Clinical Coordinator spoke to the charge nurse in the Intensive Care Unit (ICU), where resident #201 was transferred. It was shared with the Clinical Coordinator that resident #201 passed away as a result of their injury.

In an interview with the DOC in 2016, it was confirmed that the home neglected to provide resident #201 with the care required for their health and well-being. It was confirmed that there was a pattern of inaction that included no neurological assessments of the resident following the "Neurological Sign: Head Injury Routine Policy" and a time period of approximately three hours passed before resident #201 received a second assessment which jeopardized the health and well-being of the resident.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 001979-15, conducted concurrently during this Resident Quality Inspection. (Inspector #583).

C) A review of the progress notes documented on an identified date in 2015, identified resident #200 had an injury to a specified area and pain to another area, from an unknown injury during the night. The resident was assessed by staff #132

and the incident was communicated to the registered nursing staff on day shift.

A review of the next progress note documented on the day shift by staff #109, identified resident #200 reported to the Personal Support Workers (PSW) that they had a fall during the night. The resident had a specific medical history that resulted in a specified deficit. The PSWs reported to staff #109 that the resident could not fully weight bear.

In an interview with the DOC in 2016, it was confirmed a post fall assessment was not completed after resident #200 reported they had a fall and at the time of the fall the home did not have a Falls Policy in place.

The progress note documented at 1521 hours noted the resident was assessed by the physician and a test was ordered to rule out injury.

The progress note documented later, identified resident #200 had ongoing pain with movement.

A physiotherapy assessment was completed for resident #200 after the fall for complaints of pain. The assessment documented in the progress notes included specific interventions and indicated the PT would continue to monitor.

In an interview with the PT in 2016, it was confirmed their recommendations were not clearly communicated to the interdisciplinary team as resident #200's care plan was not updated or revised and staff did not comply with the recommendations made.

The progress note dated the same date as the PT assessment in 2015, provided care in contrast to the recommendations and that the resident expressed ongoing pain to a specific area.

The results of the test were faxed to the home the following day and confirmed the resident had an identified injury. A progress note dated two days after the suspected injury was sustained, identified staff #109 received the test results, the resident had continued pain with movement and that they would notify the physician of the results.

In an interview the DOC in 2016, it was confirmed that the physician was notified of the test results the day after the home received the results. A review of the Notification of Physician Policy (03-03-02) identified the physician should be notified

immediately, "If symptoms indicate medical interventions may be necessary, such as xrays, emergency treatment".

The progress note documented four days after the suspected injury occurred, identified the staff transferred resident #200 and did not comply with the PT recommendations when providing care to the resident. It was identified that further direction was required from the PT and/or physician.

The progress note documented five days after the suspected injury occurred identified that the physician spoke to resident #200 and agreed that no surgical intervention would be done in relation to their injury.

The progress note documented the same date, at 2215 hours, identified resident #200 again received care from staff that contrasted the PT's recommendations.

A progress note documented by the physician several days later (late entry for a previous date), identified that the resident had a specified injury, but was comfortable; the resident and staff had complied with the PT's recommendations and identified the injury would heal on its own; could retest in a few weeks; however, a review of the plan of care and interviews with staff and PT during the inspection confirmed the resident and staff had not complied with the PT recommendations.

The progress note documented nearly a week after the incident, identified the resident requested pain medication after being transferred into bed.

In an interview with the PT in 2016, it was confirmed that after their initial assessment, a follow up assessment was not completed until weeks later. It was confirmed that the resident was not assessed for safe positioning and transferring after it was confirmed they had an identified injury and no changes or revisions were made to resident #200's care plan. It was confirmed a falls care plan was not created until months after the fall with injury.

A review of the plan of care identified a significant change assessment was not completed after resident #200 had a confirmed injury.

In an interview with the DOC in 2016, it was confirmed that the home neglected to provide resident #200 with the care required for their health and well-being. A pattern of inaction was confirmed with the PT and the DOC, that jeopardized the health and

well-being of the resident. It included not completing the required assessments needed to determine the resident's care needs, the physician not being notified of resident #200's injury for approximately three days and the lack of collaboration between interdisciplinary team members.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 000918-15, conducted concurrently during this Resident Quality Inspection. (Inspector #583). [s. 19. (1)] (130)

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

Oct 14, 2016(A1)

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

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.

Order / Ordre :

(A1)
The licensee shall prepare submit and implement a plan describing how residents will be protected from potential risks associated with various construction or renovation related activities that are taking place within resident occupied space.

The plan shall be submitted and implemented to Bernadette.Susnik@ontario.ca by July 15, 2016.

Grounds / Motifs :

1. This Order is made based upon the application of 3 factors, severity, scope and compliance history in keeping with section 5 of the Act, in respect of the potential harm that residents would have experienced. The severity of this non-compliance was identified as a level two – potential harm/risk, the identified risks were in more than one area (pattern) and the compliance history did not include any previously issued non-compliance related to section 5 of the Act.

The licensee did not ensure that the home was a safe and secure environment for its residents.

A) On March 30, 2016, the first floor and second floor environment was observed to be unsafe and unsecure for residents. The Administrator and DOC were informed immediately of all unsafe conditions during the inspection. The Administrator was not able to provide any documentation or evidence that resident occupied zones were being inspected for health and safety hazards on a daily basis. According to the maintenance staff, a routine tour through the home was conducted daily at the beginning of the shift and would include general issues encountered on a day to day basis when the home was not undergoing any renovations. No check list or specialized routine was developed for maintenance staff with respect to construction and renovation hazards and issues.

The licensee began extensive renovations in the home in mid-2015. The plan was to construct a new section of building, connect it to the existing building and close down one wing for renovation per floor while leaving two wings occupied by residents. The 2nd floor had one wing closed down and one new wing fully occupied which opened in mid-March 2016. The new wing consisted of a sloped ramp between the new and

existing building, a chapel, administrative offices and a hair salon.

1. Next to the hair salon, a bay window was left unsecured. On March 29, 2016 and according to maintenance staff, a construction worker broke a glass panel within the bay window. No board or solid barrier was erected onto the frame to prevent cold air from entering the home or to prevent a resident from squeezing through the frame and out onto the roof. On March 30, 2016, at approximately 1000 hours the Inspector noticed the broken panel and management staff was notified of the unsecured window. The window was left unsecured at time of departure at approximately 1515 hours.

2. The hair salon on the second floor, according to the Administrator, was empty of supplies and furnishings on March 28, 2016. Inspectors #583 and #130 observed residents sitting in the space watching television prior to March 28, 2016. However, on March 29, 2016, boxes of supplies and other items were transferred into the room, including concentrated disinfectant (Barbicide) which was left on top of a counter within the room. On March 30, 2016, a resident was observed sitting in the room unsupervised with access to the disinfectant. The staff did not ensure that the various supplies were evaluated for safety risks and that they were secured before bringing residents into the room.

3. On a specified date in 2016, at approximately 0945 hours, one wing on the 1st floor was being prepared for closure. Just past the main entry to the building and across the hall from a resident sitting area, the door to the former office area was observed to be wide open and unlocked. The Inspector was able to easily walk through this area and directly into the renovation zone where ceiling tiles had been removed, wires and cabling were hanging down from the ceiling, equipment such as ladders and tools were noted and construction workers. A tarp was hung loosely from the false ceiling down to the floor along the path of travel from the visitor washroom (located next to the former office area), past the nursing office and towards wing two consisting of resident rooms. The tarp was open on either end and the renovation zone was fully accessible and visible from the resident occupied side. Construction workers were seen walking from the former unoccupied offices and into the renovation zone via the openings in the tarp.

4. A resident was sitting in a chair up against the loosely hung tarp directly in front of the nursing office. Two other chairs were placed in this area. Behind the resident, construction workers were erecting a temporary wall made of drywall and metal

framing. The sound of a nail gun was heard where a worker was connecting material directly behind and above the resident on the opposite side of the tarp. Registered staff who were sitting inside of the office were immediately informed of the safety risks.

5. The new wing on the 2nd floor was constructed with a gradual slope increasing in height between the hair salon and the administrative offices. Just in front of the administrative office entrance, an uneven area or "hump" was left in place. The hump was approximately 3 feet wide and had a prominent leading edge on one side, facing the entry door. It appeared as if the concrete that was poured in this area was not leveled out and was left in place. Trip and fall concerns for all occupants and visitors were discussed with the Administrator. (Inspector #120). [s. 5.] (120)

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

Jul 31, 2016(A1)

Order # /
Ordre no : 005

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

Linked to Existing Order /
Lien vers ordre existant:

2015_250511_0005, CO #002;

Pursuant to / Aux termes de :

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

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 :

The licensee shall ensure that all staff receives annual training on the home's policy to promote zero tolerance of abuse and neglect of residents.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (3) and compliance history (4), in keeping with s. 76 (4) of the Act, in respect to the potential for harm to residents, the scope being widespread, and the licensee's history of non-compliance. Section 76. (4) was issued as a VPC in a previous inspection in September 2014 and issued as a CO in April 2015.

The licensee failed to ensure that all staff received training on the home policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities.

A) During this inspection, the 2015 staff education records were reviewed. A review of the sign in sheets for the training on the home's abuse policy indicated that only 134 staff out of 231 had received abuse training.

It was confirmed during an interview with the ADOC on March 30, 2016, that not all staff received training on the home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities.

PLEASE NOTE: This non compliance was identified during a Follow-up Inspection, log# 011649-15, conducted concurrently during this Resident Quality Inspection. (Inspector #508). [s. 76. (4)] (130)

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

Sep 30, 2016(A1)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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
Inspection de soins de longue durée
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 29 day of June 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : GILLIAN TRACEY - (A1)

Service Area Office /
Bureau régional de services : Hamilton