Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 8, 2018	2018_580568_0008	004565-17, 005822-17, 012848-17, 021867-17, 024038-17, 028157-17, 002689-18, 003264-18, 004405-18, 006193-18, 008128-18	Complaint

Licensee/Titulaire de permis

LaPointe-Fisher Nursing Home, Limited
1934 Dufferin Avenue WALLACEBURG ON N8A 4M2

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

LaPointe-Fisher Nursing Home
271 Metcalfe Street GUELPH ON N1E 4Y8

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

DOROTHY GINTHER (568), JANET GROUX (606)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 25, 26, 27, 30, May 1, 2, 3, 4, 7, 8, 9, 10, 11, 14, 15, 16, 2018.

The following intakes were completed in this complaint inspection:
Log #004565-17, IL-49583-LO; log #005822-17, IL-49864-LO; log #012848-17, IL-51472-LO; log #021867-17, IL52900-LO; log #024038-17, IL-53544-LO; log #028157 -17, IL-54458-LO, IL-54459-LO; log #002689-18, IL-55228-LO and IL55340-LO; log #003264-18, IL-55510-LO, IL-55621-LO; log #004405-18, IL-55781-LO, IL-55893-LO; log #006193-18, IL-56233-CW; log #008128-18, IL-56565-CW related to multiple resident care concerns and staffing.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Food Service and Nutrition Manager, Registered Dietitian, Activation Manager, Pharmacist, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Maintenance staff, Laundry Aide, Activation Aide, Housekeeping staff, residents and their families.

The inspectors also reviewed the investigation notes for specified complaints, resident clinical records, relevant home policies and procedures, staffing schedules, and personnel files. They conducted observations of care being provided to residents in the home, their environment, and interactions between staff and the resident.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **13 WN(s)**
- **8 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception to this requirement.

Complaints regarding no Registered Nurse (RN) working in the home were received by the MOHLTC.

A registered practical nurse (RPN) told the Inspector that there were times when they had no registered nurse (RN) in the building and the RPNs were asked to be the charge nurse. The RPN did not feel comfortable with this responsibility but said they were not given any choice. The situation could be even more difficult when the RPNs were new graduates and had very little experience working in long term care.

The Administrator stated that in terms of staffing, the home scheduled a RN to be on duty and present in the home at all times. They worked twelve hour shifts with the exception of Thursdays when they worked eight hour shifts.

Review of the registered staff schedules identified the following:

a) For the period of June 5, 2017, to July 2, 2017, there were nine RNs on the schedule. There were two twelve hour night shifts and two eight hour day shifts where there was no RN on duty and present in the home.

b) For the period of September 25, 2017, to October 8, 2017, there were eight RNs on the schedule. There were two twelve hour day shifts and one eight hour day shift where there was no RN on duty and present in the home.

c) For the period of January 29, 2018, to February 25, 2018, there were five RNs on the schedule. There were seven twelve hour night shifts, seven twelve hour day shifts, two eight hour evening shifts, and one eight hour day shift where there was no RN on duty and present in the home.

d) For the period of February 26, 2018, to March 11, 2018, there were six RNs on the schedule. There were five twelve hour day shifts and two twelve hour night shifts where there was no RN on duty and present in the home.

During an interview with the Administrator they said they had lost a number of registered nurses in 2017, due to retirement and movement to positions outside the home. In terms of recruitment, the Administrator stated that they advertised on the Indeed website as they found this to be the most effective. They were unable to identify any other recruitment strategies utilized by the home. The Administrator said that there were shifts where they may be short an RN in which case they would bring in another RPN or the Director of Care may cover. The home was not in the practice of using agency staff.

Review of the Indeed website on May 8, 2018, showed that there was a current job posting for a registered nurse at Lapointe-Fisher Nursing Home. The job type was identified as "casual". The Administrator showed the Inspector a previous posting for an RN on the Indeed Website dated January 9 and January 29, 2018.

The Administrator acknowledged that the home did not have a registered nurse who was a member of the regular nursing staff on duty and present in the home at all times. [s. 8. (3)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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).

Findings/Faits saillants :

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

The home's policy titled "Abuse - Resident/Staff" effective March 25, 2014, and last reviewed June 26, 2017, stated under "Section Two: Reporting and Notifications about Incidents of Abuse or Neglect", that all staff were required to fulfill their legal obligation to immediately and directly report any witnessed incident or alleged incident of abuse or neglect to the MOHLTC. Staff were required to immediately report to the appropriate supervisor in the home on duty or on call at the time of the witnessed or alleged incident of abuse or neglect. When a manager/designate received an investigation report form an employee on a suspected or alleged incident of abuse or neglect they would immediately investigate the incident and report to the MOHLTC. The policy also stated that the Administrator or designate oversaw the completion of all steps required by the policy and procedures in order to the manage the case to resolution and to ensure that the reporting requirement to the MOHLTC Director was undertaken. The Administrator or designate would also ensure that a copy of the documentation was stored within a secure area.

a) A complaint letter was received by the MOHLTC in relation to an incident of alleged neglect. The letter of complaint identified that a copy of it had been given to the home's Administrator and Director of Care (DOC) soon after the incident. According to the complaint letter a staff member had left a resident during the provision of care for an extended period of time and had not alerted another staff member of their needs.

The staff member that found the resident stated that they had reported the incident to the RPN working on that floor. When asked if anyone in the home had followed up with them in regards to their report they said not directly.

In an interview with the home's Administrator they told the Inspector that the DOC was responsible for the investigation of any alleged incidents of abuse or neglect and they

also submitted the critical incidents to the MOHLTC. After being shown a copy of the complaint letter that was reportedly given to the home, the Administrator said they were aware of the allegations but it was the DOC that usually handled all the investigations. The Administrator said they were not able to find any investigation notes pertaining to this incident other than one interview with a PSW. The Administrator acknowledged that the alleged incident of neglect involving the identified resident was not reported to the Director.

b) A critical incident system (CIS) report was submitted to the MOHLTC on a specified date for an incident that occurred six days prior. The CIS report stated that a staff member reported to a RPN that a resident was found incontinent and there was no evidence that their personal hygiene had been completed on that shift. According to the report, the staff member providing care for the identified resident had left the home, but documentation stated that the resident's care had been provided.

The staff member that found the resident said they were alerted by a co-resident that the resident smelled and that they had not been washed that evening. The staff member said they reported the incident to the RPN immediately and asked them to assess the resident. The RPN said they would have filled in the occurrence report that goes to the Director of Care. The RPN said they did not recall management speaking to them about the incident as that was something they would have remembered.

In an interview with the home's Administrator they told the Inspector that the DOC was responsible for the investigation of any alleged incidents of abuse or neglect as well as the submission of critical incidents to the MOHLTC. The Administrator said they were aware of the incident as they were present during an interview with the accused staff member. The Administrator said they were not able to find any investigation notes pertaining to this incident other than one interview. The Administrator acknowledged that the alleged incident of neglect involving the identified resident was not reported to the Director immediately..

c) A CIS report was submitted to the MOHLTC on a specified date for an incident which took place nine days before. The report stated that the home received a statement from a staff member which alleged that a resident told the staff member that another staff member had not provided care when they were incontinent.

In an interview with the staff member they said they had reported the incident described in the CIS report to registered staff at the time that it occurred. The staff member said

that no one from the home's management team had followed up with them about the incident.

The Administrator told the Inspector that they were only made aware of the incident involving the identified resident when they received a letter of complaint from the staff member. The Administrator said that if a staff member had reported this to the DOC sooner they were not aware. The Administrator said they were unable to find any investigation notes and they could not recall participating in any interviews related to this incident. The Administrator acknowledged that they should have ensured that all documentation related to complaints and critical incidents were stored in a secure area. [s. 20. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the 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 is specifically designed for skin and wound assessment.

A resident's progress notes stated that the resident had an area of altered skin integrity in a specific location. There was no documentation in the resident's clinical record that an initial skin assessment was conducted by the registered nursing staff. A weekly assessment was completed which indicated that the resident continued to have the altered skin integrity as identified in the progress notes.

The home's policy titled "Skin and Wound Care" revised May 5, 2015, and last reviewed March 4, 2016, stated under the section titled "Residents with Pressure Ulcers" that upon discovery of a pressure ulcer registered staff were to initiate a baseline assessment using the wound assessment tool within point click care (PCC).

In an interview with the home's wound care lead / RPN they stated that all new wounds should be assessed by a registered staff member when they were identified and then weekly thereafter. After reviewing the identified resident's clinical record the RPN acknowledged that there was no evidence that an initial wound assessment had been completed by a registered staff member for the resident's altered skin integrity.

The licensee failed to ensure that the resident received a skin assessment, specific to the identified area of altered skin integrity, by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pan, promote healing, and prevent infection, as required.

a) A complaint was received by the MOHLTC in relation to wound care and limited supplies for dressing changes in the home.

The clinical record for a resident documented a skin assessment for an area of newly discovered altered skin integrity. There were three areas of altered skin integrity identified in the assessment with specific measurements. Two weeks later a skin assessment for an area of newly discovered altered skin integrity was completed.

Progress notes for a three month period after the the areas of altered skin integrity were identified showed that the one area specifically grew in size and severity. This area showed signs of infection and it was upwards of a month before the Endostomal (ET) nurse was able to attend the home and assess the resident. During this time the altered skin integrity worsened.

Review of the weekly skin assessments for the specified area of altered skin integrity it was noted that there was a period of three weeks and another period of two weeks where there was no skin assessment completed. There was no documentation found in the clinical record or assessments that a wound culture had been conducted.

In an interview with the home's wound care lead / RPN, they said that in their role as wound care lead they focused their time on more severe forms of altered skin integrity, seeing all residents at a minimum weekly for assessments, to determine treatment programs, and to adjust their plan of care. The RPN told the Inspector that when they first took over the program approximately six months ago there were some residents that were suffering with areas of altered skin integrity for a long time and they were not receiving proper treatment. Although the home could call the community ET Nurse for consultations related to wound care, they often had to wait several weeks for them to get to the home. The program needed someone in the home with more knowledge.

The RPN was shown the identified resident's documentation specific to the one area of altered skin integrity. In reviewing the progress notes and assessments the RPN said there were was documentation of several signs and symptoms suggestive of infection. In this type of situation, the RPN said you would want to get a culture to assist with further treatment. In addition, specific treatment techniques would need to be administered to assist with healing of the area, but they can only be performed by qualified individuals. The RPN said that before they took over the program, the home did not have anyone qualified to do this and would have to refer to the ET nurse. The RPN said that this type of treatment should be provided in a timely manner and could impact the progression of the altered skin integrity.

The identified resident developed an area of altered skin integrity on a specified date. The area progressed in severity over the following three months. Wound assessments were not completed weekly and there was no wound culture conducted despite signs of infection. The home's community ET nurse who consulted on difficult cases was only able to see the resident on two occasions, taking two weeks to respond to the home

when the resident's wound was worsening.

b) A resident's clinical record identified a newly discovered area of altered skin integrity on a specified date. A skin assessment completed the same day described the severity and size of the area. A weekly skin assessment conducted three weeks later, documented that the area had increased in size and severity, and there were now signs / symptoms of infection. No culture was done of the area. The next skin assessment was not completed until three weeks later.

The electronic treatment administration record (eTAR) for a specified time period, stated that the area of altered skin integrity was to receive a specific treatment and dressing change. The dressing changes were to take place daily and a skin assessment completed weekly.

Review of the identified resident's progress notes for the same time period identified that the specified area of altered skin integrity initially worsened and there were signs of infection. A referral was sent for the external ET nurse to assess the resident as soon as possible but it was more than a month before they were able to visit the home and assess the resident. At that point in time the resident had a new area of altered skin integrity.

In interviews with three registered staff they told the Inspector that after their regular DOC left early in 2017, they had problems with running short of wound care supplies. In these situations they were not able to follow an individual's prescribed treatment and they would dress the wound using what they had. This was evident because they saw dressings applied that did not match the resident's eTAR. One staff said that there were times when they could not change a resident's dressing because of the shortage.

In an interview with the wound care lead / RPN they stated that prior to taking on the role, the Acting DOC had been the lead for the program. At that time if a resident had a difficult skin concern they would refer to the ET nurse in the community. The RPN acknowledged that in the identified resident's situation, it took more than a month before the ET nurse visited the home to assess the resident's altered skin integrity after it was documented that they had been notified by email. Weekly skin/wound assessments were not being conducted and there were no cultures taken of the wound despite signs of infection and worsening of the skin concern. Documented treatments on three specific dates were not consistent with the eTAR.

The licensee failed to ensure that the identified two residents received immediate treatment and interventions to promote healing and prevent infection, for areas of altered skin integrity. [s. 50. (2) (b) (ii)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a) An anonymous complaint was received by the MOHLTC which identified that a resident had a chronic area of altered skin integrity which became infected and they were concerned that the resident was not receiving proper treatment.

(i) The clinical record for the identified resident documented a skin assessment for an area of newly discovered altered skin integrity. There were three areas identified in the assessment.

There were no weekly skin assessments completed on two of the three weeks during the first month after the areas of altered skin integrity were identified, no weekly skin assessments for two of the areas of altered skin integrity on two of the four weeks in the following month. Treatments continued for two of the areas for two weeks after the last weekly skin assessment.

The wound care lead / RPN said that areas of altered skin integrity should be assessed weekly by a registered staff until the area had healed. The RPN reviewed the documentation for the identified resident and acknowledged that there were periods of up to two weeks where the resident's two areas of altered skin integrity were not assessed.

(ii) The clinical record for a resident documented a skin assessment on a specified date, for an area of newly discovered altered skin integrity.

During a specified month there was one out of four weekly skin assessments not completed, during a second month there were two out of four weekly skin assessments not completed. There were no weekly skin assessments completed for the area of altered skin integrity for a two week period in the third month although treatments continued to be documented in the eTAR.

The RPN reviewed the documentation for the identified resident and acknowledged that there were periods of up to three weeks where the resident's altered skin integrity was

not assessed.

b) The clinical record for an identified resident documented the following:

(i) A skin assessment on on a specified date, for an area of newly discovered altered skin integrity. During the next eight week period there was only one weekly skin assessment documented for the area of altered skin integrity despite treatment being provided as outlined in the eTAR.

(ii) A skin assessment on a specified date, for an area of newly discovered altered skin integrity. There were no weekly skin assessments in relation to the specified area of altered skin integrity on one out of four weeks in the first month, two out of four weeks in the second month, one of of four weeks in the third month, and one out of two weeks in the the fourth month.

(iii) A progress note on a specified date, documented that the resident had an area of altered skin integrity. There were no weekly skin assessments completed in relation to the specified area of altered skin integrity on two out of three weeks in the first months and one one out of three weeks in the second month.

In an interview with the home's wound care lead / RPN, they stated that it was the home's expectation that all areas of altered skin integrity be assessed at a minimum weekly. The RPN reviewed the documentation for the identified resident with respect to their skin assessments and acknowledged that weekly skin assessments had not been completed for the identified resident's three separate areas of altered skin integrity. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

Review of a complaint submitted to the MOHLTC indicated that an identified resident was at risk for falls and required specific interventions to mitigate that risk. The complainant alleged that on a regular basis the staff did not implement the specific interventions and that the resident had a recent fall but was not injured.

Review of the resident's written care plan identified that the resident was a high risk for falls. The plan of care outlined interventions specific to the resident to mitigate the risk of falls. The care plan indicated that that the resident was to have a device applied which was considered a Personal Assistance Services Device (PASD). The device in place could be removed by the resident on their own.

Review of the resident's progress notes on a specified date, identified documentation that the resident had a fall. The resident was assessed by registered staff and found to have no injuries from the fall. The progress notes stated that a recreation staff member had just brought the resident back to the home area prior to the fall.

During an interview with the staff member that brought the resident back to the home area, they said that after the fall they were told by registered staff that they should have implemented a specific intervention to mitigate the risk of falls for this resident prior to leaving them alone. The staff member said they had not implemented this intervention as they were not aware of it. They further stated that they did not have access to the resident's individual care plans but would receive verbal directions and information from the charge nurse as required.

In an interview with a RPN, they indicated that the identified resident had a fall with no injuries on the date indicated. The RPN stated that staff were directed to monitor the

resident because they were a high falls risk. During the post fall assessment they noted that a specific intervention designed to mitigate the resident's risk of falls had not been implemented. The RPN then educated the staff member involved with respect to falls interventions for the identified resident.

During an interview with the Activation Manager they said that recreation staff usually receive their information about residents from information collected during admissions, interdisciplinary team conferences and observations recorded by the staff themselves. Although they do not encourage it, the recreation staff can access the residents care plan if they wanted to in Point Click Care (PCC) using a "code", posted at each nursing station.

The licensee failed to ensure that the staff and others who provide direct care to the resident were kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. [s. 6. (8)]

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 staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were free from neglect by the licensee or staff in the home.

O. Reg. 79/10, s. 5. defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one of more residents.

A CIS report submitted to the MOHLTC described an alleged incident of neglect. A staff member reported to registered staff that a resident was found incontinent, and there was no evidence that they had been provided assistance with their personal hygiene on that shift. The staff member overseeing the resident's care had left the home, but documentation stated that care had been provided.

The identified resident's Minimum Data Set (MDS) assessment stated that the resident was incontinent and required assistance from staff for completing their personal hygiene.

The home provided the Inspector with a copy of an interview conducted by management with the staff member involved in the incident. At that time they stated that on the specified date, they had changed the resident when they were incontinent. They thought they had provided personal hygiene afterward but may not have completed the task. The staff member said that they did not provide all of their personal care as the resident was sleeping.

In an interview with a co-resident they stated that at the time of the alleged incident they lived in the same room as the identified resident. They recalled a specific incident where they reported to a staff member that the identified resident smelled and had not had their continence care or personal hygiene completed by the staff assigned to them. The co-resident could not recall the exact date that this occurred but they were able to remember the staff member they reported it to.

In an interview with the staff member that reported the incident, they told the Inspector that what they remembered about the incident was that the resident said they had not had their personal hygiene done and this was confirmed by a co-resident. When this staff member checked on the resident they found that they had not had proper continence care or personal hygiene completed. The staff member said they reported the incident to the registered staff on the floor and asked them to come and see how the resident had been left. The registered staff came to the room and observed that the resident's personal hygiene had not been done and their personal care items had not be used.

The RPN involved with this incident stated that they remembered a situation where a staff member reported to them that the identified resident had not received continence care and personal hygiene from the staff member assigned to them. When they went to check on the resident they confirmed that the continence care had not been provided and that there was no evidence they had received assistance with their personal hygiene. The RPN said they ensured the resident received the appropriate care and reported the incident to the charge nurse. The charge nurse would have completed a supervisor report that goes to the management. When asked if they recalled being spoken to by the management about this incident they said they did not think so.

The licensee failed to ensure that the identified resident was protected from neglect by the licensee and staff in the home. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, was immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations; (b) appropriate action is taken in response to every such incident; and (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with.

a) A CIS report was submitted to the MOHLTC on a specified date, for an incident which took place nine days before. The report stated that the home received a statement from a staff member on the same day they submitted the report, which alleged that a resident told a staff member that another staff member had not provided them with continence care and personal hygiene.

In an interview with the staff member that reported the incident they said that they had reported the incident described in the CIS report to registered staff at the time that it occurred. The staff member said that no one from the home's management team had followed up with them about the incident.

The Administrator told the Inspector that they were only made aware of the incident involving the identified resident on the day the CIS report was submitted. The Administrator said they were unable to find any investigation notes pertaining to the incident.

b) Review of a complaint submitted to the MOHLTC on a specified date, alleged that a resident was transferred to the hospital with an injury of unknown cause.

Review of the resident's progress notes identified documentation that the home received a verbal report from the home's imaging provider which indicated the nature of the resident's injury. The progress notes stated that the physician was notified, ordered specific treatment for the injury, and the SDM was notified of the injury. The resident was transferred to the hospital for further treatment.

Interview with the SDM indicated they had concerns with how the resident sustained the injury and they brought their concern to the DOC in the home at the time.

In an interview with the Administrator, they stated that it was the home's practice that any concern forwarded by anyone to the home was followed up and investigated. The Administrator said there was no follow up or investigation into the concern by the identified resident's SDM. (#606)

The licensee failed to ensure that the incidents of alleged neglect / abuse involving the identified two residents were immediately investigated. [s. 23. (1) (a)]

2. The licensee failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action under clause (1) (b.)

A CIS report was submitted to the Director on a specified date, for an incident of alleged neglect that took place six days prior. A staff member reported to registered staff that a resident did not receive proper care related to continence and personal hygiene from the staff member assigned to their care. The CIS report documented under the section "Analysis and follow-up" that the staff member had been suspended pending an investigation. There was no amendment to the CIS report with respect to the outcome of the investigation.

During an interview with the Administrator they agreed that the CIS report had not been

amended and acknowledged that the results of the investigation were not reported to the Director.

The licensee failed to ensure that the results of the investigation related to a critical incident were reported to the Director. [s. 23. (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 every alleged, suspected or witnessed incident of abuse or neglect that the licensee knows of, or that is reported is immediately investigated and the results are reported to the Director, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the

suspicion and the information upon which it was based to the Director:
Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.
Neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

a) A CIS report was submitted to the Director on a specified date, for an incident of alleged neglect that took place six days prior. A staff member reported to registered staff that a resident did not receive continence care and personal hygiene from the staff member assigned to their care.

In an interview with the staff member that reported the incident to registered staff, they stated that they reported the incident described in the CIS report to the RPN on duty immediately. The RPN stated that they would have advised the charge nurse of the incident and completed a supervisor report.

The Administrator told this Inspector that it was the responsibility of the DOC to investigate alleged incidents of abuse and neglect and to submit the critical incident reports to the Director. The Administrator acknowledged that the incident should have been reported to the Director immediately and it had not been done.

b) A PSW and registered staff told an Inspector that there was an incident on a specified date, where a resident was found incontinent with poor hygiene. The RPN stated that they advised the PSW to provide personal hygiene for the resident and immediately reported the incident to the home's Administrator #115.

The Administrator stated that the RPN on duty had called them to report the alleged incident of neglect involving the identified resident. The Administrator said that they were so busy with the investigation of the incident they had not reported it to the Director. Two weeks later they recognized that it had not been reported but decided there was no point as it was too late.

c) A complaint was received by the MOHLTC in relation to an incident that took place on a specified date. According to the complaint, a resident had been left by a staff member in the middle of care and they had not advised another staff member. After a period of time, the resident was able to alert another staff member and they attended to the resident's immediate needs.

The Administrator told the Inspector that they were aware that the Director should have

been notified of the alleged incident of improper care or incompetent treatment of the identified resident, but stated it "must have got missed".

The licensee failed to ensure that the person who had reasonable grounds to suspect that neglect and improper care of residents by the licensee or staff, that resulted in harm or risk of harm, was immediately reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.
2. Neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 46. Every licensee of a long-term care home shall ensure that every member of the staff who performs duties in the capacity of registered nurse, registered practical nurse or registered nurse in the extended class has the appropriate current certificate of registration with the College of Nurses of Ontario. O. Reg. 79/10, s. 46.

Findings/Faits saillants :

1. The licensee has failed to ensure that every member of the registered nursing staff (registered nurse, registered practical nurse, registered nurse in the extended class) has the appropriate current certificate of registration with the College of Nurses of Ontario.

Review of the registered staff schedule for January 29, 2018, identified that two RPNs were scheduled to work the day shift. There was no indication on the schedule that these shifts were a part of either staff members orientation. The registered staff schedule did not have a RN scheduled to work the day shift on January 29, 2018.

The personnel file for one of the RPN's included a copy of their Orientation Check List which identified that the RPN's date of employment was January 12, 2018. The Check List documented that the RPN had participated in orientation with other RPNs on each of the day, evening and night shifts, but there were no specified dates for the orientation. The RPN's personnel file also contained a copy of the staff member's initial registration with the College of Nurses of Ontario and it was dated January 31, 2018.

In an interview with the second RPN, they stated that they remembered working the day shift on January 29, 2018, because they were asked to be the charge nurse in the absence of an RN in the home. During that shift they were made aware by another staff member that one of the RPNs was not registered with the College of Nurses of Ontario.

The Administrator told the Inspector that before registered staff can work in the home they must have their professional designation and be registered with the College of Nurses of Ontario (CNO). When shown the staff schedule and the CNO registration for the identified RPN, the Administrator said they only became aware after the fact that the RPN had worked one regular shift and several orientation shifts without their registration. Once made aware they took them off the schedule until their registration was confirmed. The Administrator acknowledged that the home failed to ensure that the identified RPN had the appropriate current registration with the CNO before commencing work in the home.

The licensee failed to ensure that every member of the registered nursing staff had the appropriate current certificate of registration with the College of Nurses of Ontario. [s. 46.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every registered nursing staff (registered nurse, registered practical nurse, registered nurse in the extended class) have the appropriate current certificate of registration with the College of Nurses of Ontario, 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,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes.

During the inspection, the Inspector saw a PSW come out of a resident's room and ask a registered staff member for a continence product. The registered staff was observed to get on the elevator. The Resident remained in the bathroom with a second PSW. The

PSW left the area and went to provide care for another resident. More than five minutes passed and the first PSW returned to ask the second PSW if the nurse had brought the continence product. The second PSW said they had not and they remained in the washroom with the resident. Soon after, the registered staff stepped off the elevator and handed a continence product to the PSW who then went into the identified resident's bathroom.

In an interview with one of the PSWs involved in the described situation, they stated that the identified resident needed assistance with toileting and wore a continence product in relation to their incontinence. When asked if continence products were available and accessible to staff at all times, they stated "not always". Each shift a continence supply bin was brought to the floor and the staff would collect the product for their residents and put it in their room. Residents were allotted one or two changes on each shift depending on the resident. The PSW said that the identified resident had one change each shift. If the resident required another product the PSW would have to ask a registered staff to access the extra product from the locked treatment room. Two PSWs told this Inspector that this could be difficult at times because if the nurse was on break or busy at the time they would have to wait for the product. That would mean that the resident had to wait and sometimes the resident was already in the washroom or on the bed half changed. If the prescribed continence product was not in the emergency supply bin, the nurse would have to go downstairs to get more. The PSW said they had experienced that very problem this week when a resident was left waiting on the toilet for close to ten minutes while a registered staff went downstairs to get their product.

In an interview with the Continence Lead / RAI Coordinator they stated that each resident had an allotted number of continence products for each shift. An emergency supply was kept in the locked treatment room which the registered staff had access to. The Continence Lead acknowledged that if a resident was waiting on the toilet for almost ten minutes to get a continence product then the product was not available and accessible to the resident and staff.

The licensee failed to ensure that continence products were available and accessible to the identified resident and staff at all times, and in sufficient quantities for all required changes. [s. 51. (2) (f)]

2. The licensee has failed to ensure that residents were provided with a range of continence care products based on their individual assessed care needs.

A resident's admission continence assessment identified that the resident had a history of incontinence. The resident wore a continence product and used a specified number of products in twenty four hours. According to the most recent Prevail resident worksheet the identified resident had a specified product type but the number alloted to the resident for twenty four hours was less than that recommended in the continence assessment.

The Continence Lead and RAI Coordinator told this Inspector that the home just recently changed their continence product provider. When a resident was first admitted a continence assessment would be completed by registered staff as well as a Prevail product assessment. Once completed the Prevail assessment would be given to the RAI Coordinator so they could order the appropriate products. In addition, it was the home's expectation that a three day voiding diary would be completed by the PSW's to assist with the toileting plan and continence product needs.

There was no documentation in the identified resident's electronic and paper clinical record of a Prevail product assessment or three day voiding diary.

The Continence Lead and RAI Coordinator was not able to find a Prevail product assessment for the identified resident and said that when they spoke with registered staff they said they just "eyeball" the assessment to determine the type of product to be used. In terms of the voiding diary, the Continence lead said they found the form but it had not been completed for the identified resident.

The licensee failed to ensure that the identified resident was provided with a range of continence care products based on their individual assessed needs. [s. 51. (2) (h) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that there a range of continence care products are available and accessible to residents and staff at all times, and in sufficient quantities for all required changes, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. 2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. 3. A response shall be made to the person who made the complaint, indicating, i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

Review of a complaint submitted to the MOHLTC on a specified date, indicated concerns regarding a fall by a resident that resulted in injury.

Record review indicated no evidence of any investigation documents.

In an interview with the Administrator they stated that the home did not complete a follow up investigation with respect to the concerns brought to their attention by the identified resident’s SDM regarding the fall and resulting injury. [s. 101. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. 2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. 3. A response shall be made to the person who made the complaint, indicating, i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

a) Review of a complaint submitted to the MOHLTC on a specified date, alleged that a resident sustained an injury of unknown cause which resulted in their transfer to hospital.

Review of the resident's progress notes for a specified date, indicated documentation that the home received a verbal report from the home's imaging provider that the resident had a specified injury. The progress notes indicated the physician was notified and ordered a specific treatment regime. The resident went to hospital for further treatment of the injury and returned to the home.

In an interview with the Administrator they stated that the home did not submit a CIS report for the incident where the identified resident sustained an injury requiring transfer to hospital.

b) Review of a complaint submitted to the MOHLTC on a specified date, identified concerns regarding a fall by a resident which resulted in injury.

The identified Resident's progress notes documented that a RN was notified by PSW that a resident had fallen. The progress notes stated that the resident was transferred to the hospital for further investigation and treatment of their injury and was readmitted to the home the next day with a specified diagnoses and treatment plan.

In an interview the Administrator stated that the home did not submit a CIS report for the identified resident's injury that required transfer to hospital.

The licensee has failed to ensure that the Director was informed of incidents where two residents were injured and taken to hospital. [s. 107. (3) 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 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): An injury in respect of which a person is taken to hospital, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (2) The licensee shall ensure that each resident receives assistance, if required, to insert dentures prior to meals and at any other time as requested by the resident or required by the resident's plan of care. O. Reg. 79/10, s. 34 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the resident received assistance, if required, to insert dentures prior to meals and at any time when requested by the resident or required by the resident's plan of care.

Review of a complaint submitted to the MOHLTC on a specified date, alleged that staff were not putting the resident's dentures in when feeding them as required.

During the inspection the identified resident was observed without their dentures in place. The dentures were seen in a blue denture cup on the resident's night stand. The resident acknowledged that they were not wearing their dentures that morning.

In an interview with a PSW they stated that the identified resident was not wearing their dentures during breakfast and lunch on the specified date because they had forgotten to offer them to the resident.

The licensee failed to ensure that the identified resident received assistance to insert their dentures prior to meals when requested by the resident or required by the resident's plan of care. [s. 34. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident was notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A PSW and RPN told the Inspector that there was an incident on a specified date, where a resident was found incontinent with poor hygiene. The RPN stated that they immediately reported the incident to the home's Administrator.

In a review of the investigation notes for the identified incident, as well as the plan of care for the resident there was no documentation which indicated that the resident's SDM was notified of the alleged incident of neglect.

The Administrator confirmed that the identified resident's SDM was not notified of the incident of alleged neglect which had been reported to the home.

The licensee has failed to ensure that the identified resident's SDM was notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of neglect of the resident. [s. 97. (1) (b)]

Issued on this 27th day of August, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DOROTHY GINTHER (568), JANET GROUX (606)
Inspection No. / No de l'inspection :	2018_580568_0008
Log No. / No de registre :	004565-17, 005822-17, 012848-17, 021867-17, 024038-17, 028157-17, 002689-18, 003264-18, 004405-18, 006193-18, 008128-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 8, 2018
Licensee / Titulaire de permis :	LaPointe-Fisher Nursing Home, Limited 1934 Dufferin Avenue, WALLACEBURG, ON, N8A-4M2
LTC Home / Foyer de SLD :	LaPointe-Fisher Nursing Home 271 Metcalfe Street, GUELPH, ON, N1E-4Y8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dahlia Burt-Gerrans

To LaPointe-Fisher Nursing Home, Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must be compliant with s. 8. (3) of the LTCHA.

Specifically the licensee must:
a) Ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception for this requirement.
b) Ensure that the licensee keeps a record of all recruitment strategies specific to registered nurses.

Grounds / Motifs :

1. The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception to this requirement.

Complaints regarding no Registered Nurse (RN) working in the home were received by the MOHLTC.

A registered practical nurse (RPN) told the Inspector that there were times when they had no registered nurse (RN) in the building and the RPNs were asked to be the charge nurse. The RPN did not feel comfortable with this responsibility but said they were not given any choice. The situation could be even more difficult when the RPNs were new graduates and had very little experience working in long term care.

The Administrator stated that in terms of staffing, the home scheduled a RN to be on duty and present in the home at all times. They worked twelve hour shifts with the exception of Thursdays when they worked eight hour shifts.

Review of the registered staff schedules identified the following:

a) For the period of June 5, 2017, to July 2, 2017, there were nine RNs on the schedule. There were two twelve hour night shifts and two eight hour day shifts where there was no RN on duty and present in the home.

b) For the period of September 25, 2017, to October 8, 2017, there were eight RNs on the schedule. There were two twelve hour day shifts and one eight hour day shift where there was no RN on duty and present in the home.

c) For the period of January 29, 2018, to February 25, 2018, there were five RNs on the schedule. There were seven twelve hour night shifts, seven twelve hour day shifts, two eight hour evening shifts, and one eight hour day shift where there was no RN on duty and present in the home.

d) For the period of February 26, 2018, to March 11, 2018, there were six RNs on the schedule. There were five twelve hour day shifts and two twelve hour night shifts where there was no RN on duty and present in the home.

During an interview with the Administrator they said they had lost a number of registered nurses in 2017, due to retirement and movement to positions outside the home. In terms of recruitment, the Administrator stated that they advertised on the Indeed website as they found this to be the most effective. They were unable to identify any other recruitment strategies utilized by the home. The Administrator said that there were shifts where they may be short an RN in which case they would bring in another RPN or the Director of Care may cover. The home was not in the practice of using agency staff.

Review of the Indeed website on May 8, 2018, showed that there was a current job posting for a registered nurse at Lapointe-Fisher Nursing Home. The job type was identified as "casual". The Administrator showed the Inspector a previous posting for an RN on the Indeed Website dated January 9 and January 29, 2018.

The Administrator acknowledged that the home did not have a registered nurse

who was a member of the regular nursing staff on duty and present in the home at all times

The severity of this issue was determined to be a level two as there was a potential for actual harm to residents. The scope of the issue was a level two as it related to shifts over at least six of the twelve months reviewed. The home had a level three history with one or more related noncompliance in the last 36 months.

CO issued September 24, 2015, inspection #2015_226192_0050

(568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 19, 2018

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 20. (1) of the LTCHA.

Specifically the licensee must:
a) Ensure that all staff receive education related to the home's policy to promote zero tolerance of abuse and neglect of residents and that this education specifically addresses the duty to report and the process that each staff member is to follow with respect to reporting. A record of the education, the dates offered and who attended must be kept.
b) Ensure that the management staff of the home follow their process for investigation of the alleged incidents of abuse/neglect, and that records are kept of the investigation and these records are stored in a secure area.
c) Ensure that the Administrator or designate is aware of and oversees the investigation process and has access to the investigation records.

Grounds / Motifs :

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

The home's policy titled "Abuse - Resident/Staff" effective March 25, 2014, and last reviewed June 26, 2017, stated under "Section Two: Reporting and Notifications about Incidents of Abuse or Neglect", that all staff were required to fulfill their legal obligation to immediately and directly report any witnessed incident or alleged incident of abuse or neglect to the MOHLTC. Staff were required to immediately report to the appropriate supervisor in the home on duty or on call at the time of the witnessed or alleged incident of abuse or neglect.

When a manager/designate received an investigation report from an employee on a suspected or alleged incident of abuse or neglect they would immediately investigate the incident and report to the MOHLTC. The policy also stated that the Administrator or designate oversaw the completion of all steps required by the policy and procedures in order to the manage the case to resolution and to ensure that the reporting requirement to the MOHLTC Director was undertaken. The Administrator or designate would also ensure that a copy of the documentation was stored within a secure area.

a) A complaint letter was received by the MOHLTC in relation to an incident of alleged neglect. The letter of complaint identified that a copy of it had been given to the home's Administrator and Director of Care (DOC) soon after the incident. According to the complaint letter a staff member had left a resident during the provision of care for an extended period of time and had not alerted another staff member of their needs.

The staff member that found the resident stated that they had reported the incident to the RPN working on that floor. When asked if anyone in the home had followed up with them in regards to their report they said not directly.

In an interview with the home's Administrator they told the Inspector that the DOC was responsible for the investigation of any alleged incidents of abuse or neglect and they also submitted the critical incidents to the MOHLTC. After being shown a copy of the complaint letter that was reportedly given to the home, the Administrator said they were aware of the allegations but it was the DOC that usually handled all the investigations. The Administrator said they were not able to find any investigation notes pertaining to this incident other than one interview with a PSW. The Administrator acknowledged that the alleged incident of neglect involving the identified resident was not reported to the Director.

b) A critical incident system (CIS) report was submitted to the MOHLTC on a specified date for an incident that occurred six days prior. The CIS report stated that a staff member reported to a RPN that a resident was found incontinent and there was no evidence that their personal hygiene had been completed on that shift. According to the report, the staff member providing care for the identified resident had left the home, but documentation stated that the resident's care had been provided.

The staff member that found the resident said they were alerted by a co-resident that the resident smelled and that they had not been washed that evening. The staff member said they reported the incident to the RPN immediately and asked them to assess the resident. The RPN said they would have filled in the occurrence report that goes to the Director of Care. The RPN said they did not recall management speaking to them about the incident as that was something they would have remembered.

In an interview with the home's Administrator they told the Inspector that the DOC was responsible for the investigation of any alleged incidents of abuse or neglect as well as the submission of critical incidents to the MOHLTC. The Administrator said they were aware of the incident as they were present during an interview with the accused staff member. The Administrator said they were not able to find any investigation notes pertaining to this incident other than one interview. The Administrator acknowledged that the alleged incident of neglect involving the identified resident was not reported to the Director immediately.

c) A CIS report was submitted to the MOHLTC on a specified date for an incident which took place nine days before. The report stated that the home received a statement from a staff member which alleged that a resident told the staff member that another staff member had not provided care when they were incontinent.

In an interview with the staff member they said they had reported the incident described in the CIS report to registered staff at the time that it occurred. The staff member said that no one from the home's management team had followed up with them about the incident.

The Administrator told the Inspector that they were only made aware of the incident involving the identified resident when they received a letter of complaint from the staff member. The Administrator said that if a staff member had reported this to the DOC sooner they were not aware. The Administrator said they were unable to find any investigation notes and they could not recall participating in any interviews related to this incident. The Administrator acknowledged that they should have ensured that all documentation related to complaints and critical incidents were stored in a secure area.

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

The severity of this issue was determined to be a level two as there was potential for actual harm to residents. The scope was a level two, pattern, affecting two out of four residents. The home had a level three compliance history with one or more related noncompliance in the last 36 months.

VPC issued May 17, 2017, inspection #2017_604519_0006
(568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 19, 2018

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with s. 50 (2) (b) (i), (ii), (iv) of O. Reg. 79/10.

Specifically the licensee must:
a) Ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment
b) Ensure that residents exhibiting altered skin integrity receives immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection.
c) Ensure that residents exhibiting altered skin integrity are reassessed at least weekly by a member of the registered nursing staff if clinically indicated.
d) Ensure that residents exhibiting altered skin integrity receive treatment as directed by the plan of care and that the treatment is documented.
e) Ensure that all registered staff receive education related to skin and wound assessment and treatment and that a record is kept of the education.
f) Ensure that the home has access to specialized resources in relation to skin and wound care and that when needed referrals are made in a timely manner.
g) Ensure that there are adequate supplies available for the treatment of wounds based on the plan of care and that there is a process in place to ensure that supplies are monitored and ordered on a regular basis.

Grounds / Motifs :

1. The licensee has failed to ensure that the 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 is specifically designed for skin and wound assessment.

A resident's progress notes stated that the resident had an area of altered skin integrity in a specific location. There was no documentation in the resident's clinical record that an initial skin assessment was conducted by the registered nursing staff. A weekly assessment was completed which indicated that the resident continued to have the altered skin integrity as identified in the progress notes.

The home's policy titled "Skin and Wound Care" revised May 5, 2015, and last reviewed March 4, 2016, stated under the section titled "Residents with

Pressure Ulcers" that upon discovery of a pressure ulcer registered staff were to initiate a baseline assessment using the wound assessment tool within point click care (PCC).

In an interview with the home's wound care lead / RPN they stated that all new wounds should be assessed by a registered staff member when they were identified and then weekly thereafter. After reviewing the identified resident's clinical record the RPN acknowledged that there was no evidence that an initial wound assessment had been completed by a registered staff member for the resident's altered skin integrity.

The licensee failed to ensure that the resident received a skin assessment, specific to the identified area of altered skin integrity, by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment
(568)

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

a) A complaint was received by the MOHLTC in relation to wound care and limited supplies for dressing changes in the home.

The clinical record for a resident documented a skin assessment for an area of newly discovered altered skin integrity. There were three areas of altered skin integrity identified in the assessment with specific measurements. Two weeks later a skin assessment for an area of newly discovered altered skin integrity was completed.

Progress notes for a three month period after the the areas of altered skin integrity were identified showed that the one area specifically grew in size and severity. This area showed signs of infection and it was upwards of a month before the Endostomal (ET) nurse was able to attend the home and assess the resident. During this time the altered skin integrity worsened.

Review of the weekly skin assessments for the specified area of altered skin integrity it was noted that there was a period of three weeks and another period

of two weeks where there was no skin assessment completed. There was no documentation found in the clinical record or assessments that a wound culture had been conducted.

In an interview with the home's wound care lead / RPN, they said that in their role as wound care lead they focused their time on more severe forms of altered skin integrity, seeing all residents at a minimum weekly for assessments, to determine treatment programs, and to adjust their plan of care. The RPN told the Inspector that when they first took over the program approximately six months ago there were some residents that were suffering with areas of altered skin integrity for a long time and they were not receiving proper treatment. Although the home could call the community ET Nurse for consultations related to wound care, they often had to wait several weeks for them to get to the home. The program needed someone in the home with more knowledge.

The RPN was shown the identified resident's documentation specific to the one area of altered skin integrity. In reviewing the progress notes and assessments the RPN said there were was documentation of several signs and symptoms suggestive of infection. In this type of situation, the RPN said you would want to get a culture to assist with further treatment. In addition, specific treatment techniques would need to be administered to assist with healing of the area, but they can only be performed by qualified individuals. The RPN said that before they took over the program, the home did not have anyone qualified to do this and would have to refer to the ET nurse. The RPN said that this type of treatment should be provided in a timely manner and could impact the progression of the altered skin integrity.

The identified resident developed an area of altered skin integrity on a specified date. The area progressed in severity over the following three months. Wound assessments were not completed weekly and there was no wound culture conducted despite signs of infection. The home's community ET nurse who consulted on difficult cases was only able to see the resident on two occasions, taking two weeks to respond to the home when the resident's wound was worsening.

b) A resident's clinical record identified a newly discovered area of altered skin integrity on a specified date. A skin assessment completed the same day described the severity and size of the area. A weekly skin assessment conducted three weeks later, documented that the area had increased in size

and severity, and there were now signs / symptoms of infection. No culture was done of the area. The next skin assessment was not completed until three weeks later.

The electronic treatment administration record (eTAR) for a specified time period, stated that the area of altered skin integrity was to receive a specific treatment and dressing change. The dressing changes were to take place daily and a skin assessment completed weekly.

Review of the identified resident's progress notes for the same time period identified that the specified area of altered skin integrity initially worsened and there were signs of infection. A referral was sent for the external ET nurse to assess the resident as soon as possible but it was more than a month before they were able to visit the home and assess the resident. At that point in time the resident had a new area of altered skin integrity.

In interviews with three registered staff they told the Inspector that after their regular DOC left early in 2017, they had problems with running short of wound care supplies. In these situations they were not able to follow an individual's prescribed treatment and they would dress the wound using what they had. This was evident because they saw dressings applied that did not match the resident's eTAR. One staff said that there were times when they could not change a resident's dressing because of the shortage.

In an interview with the wound care lead / RPN they stated that prior to taking on the role, the Acting DOC had been the lead for the program. At that time if a resident had a difficult skin concern they would refer to the ET nurse in the community. The RPN acknowledged that in the identified resident's situation, it took more than a month before the ET nurse visited the home to assess the resident's altered skin integrity after it was documented that they had been notified by email. Weekly skin/wound assessments were not being conducted and there were no cultures taken of the wound despite signs of infection and worsening of the skin concern. Documented treatments on three specific dates were not consistent with the eTAR.

The licensee failed to ensure that the identified two residents received immediate treatment and interventions to promote healing and prevent infection, for areas of altered skin integrity
(568)

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a) An anonymous complaint was received by the MOHLTC which identified that a resident had a chronic area of altered skin integrity which became infected and they were concerned that the resident was not receiving proper treatment.

(i) The clinical record for the identified resident documented a skin assessment for an area of newly discovered altered skin integrity. There were three areas identified in the assessment.

There were no weekly skin assessments completed on two of the three weeks during the first month after the areas of altered skin integrity were identified, no weekly skin assessments for two of the areas of altered skin integrity on two of the four weeks in the following month. Treatments continued for two of the areas for two weeks after the last weekly skin assessment.

The wound care lead / RPN said that areas of altered skin integrity should be assessed weekly by a registered staff until the area had healed. The RPN reviewed the documentation for the identified resident and acknowledged that there were periods of up to two weeks where the resident's two areas of altered skin integrity were not assessed.

(ii) The clinical record for a resident documented a skin assessment on a specified date, for an area of newly discovered altered skin integrity.

During a specified month there was one out of four weekly skin assessments not completed, during a second month there were two out of four weekly skin assessments not completed. There were no weekly skin assessments completed for the area of altered skin integrity for a two week period in the third month although treatments continued to be documented in the eTAR.

The RPN reviewed the documentation for the identified resident and acknowledged that there were periods of up to three weeks where the resident's altered skin integrity was not assessed.

b) The clinical record for an identified resident documented the following:

(i) A skin assessment on on a specified date, for an area of newly discovered altered skin integrity. During the next eight week period there was only one weekly skin assessment documented for the area of altered skin integrity despite treatment being provided as outlined in the eTAR.

(ii) A skin assessment on a specified date, for an area of newly discovered altered skin integrity. There were no weekly skin assessments in relation to the specified area of altered skin integrity on one out of four weeks in the first month, two out of four weeks in the second month, one of of four weeks in the third month, and one out of two weeks in the the fourth month.

(iii) A progress note on a specified date, documented that the resident had an area of altered skin integrity. There were no weekly skin assessments completed in relation to the specified area of altered skin integrity on two out of three weeks in the first months and one one out of three weeks in the second month.

In an interview with the home's wound care lead / RPN, they stated that it was the home's expectation that all areas of altered skin integrity be assessed at a minimum weekly. The RPN reviewed the documentation for the identified resident with respect to their skin assessments and acknowledged that weekly skin assessments had not been completed for the identified resident's three separate areas of altered skin integrity.

The severity of this issue was determined to be a level three as there was actual harm to residents. The scope of the issue was a pattern, affecting two out of three residents reviewed. The home had a level five history, multiple non-compliances with at least one related order to the current area of concern.

CO September 24, 2015, inspection #2015_226192_0050
VPC March 10, 2017, inspection #2017_604519_0004
(568)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 19, 2018

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 8th day of August, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : Dorothy Ginther

Service Area Office /
Bureau régional de services : Central West Service Area Office