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 # / Registre no	Type of Inspection / Genre d'inspection
Sep 2, 2016	2016_332575_0014	011366-16	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

Waters Edge Care Community
401 WILLIAM STREET NORTH BAY ON P1A 1X5

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

LINDSAY DYRDA (575), ALAIN PLANTE (620), CHAD CAMPS (609), SYLVIE BYRNES (627), SYLVIE LAVICTOIRE (603)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 16-20 and 24-27, 2016. An additonal interview was conducted on June 14, 2016.

Additional logs inspected during this RQI include:
Critical Incidents (CI):
Five related to allegations of staff to resident abuse;
One related to a controlled substance missing/unaccounted for;
Four related to falls of residents; and
One related to a respiratory outbreak.

Complaints:
Three related to bed refusals and timelines for responding to applications for admission; and
Nine related to staff shortages affecting resident care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Food Service Manager (FSM), Social Worker, Physiotherapist, Environmental Supervisor (ES), Maintenance Supervisor (MS), Resident Assessment Instrument (RAI) Coordinator, Resident Program staff, Dietary Aides, Housekeeping staff, North Bay Police, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Community Care Access Centre (CCAC) staff, students, family members, and residents.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **23 WN(s)**
- **14 VPC(s)**
- **7 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. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

During an interview with Inspector #603, RN #114 explained that resident #013 did not have any skin breakdown or pressure ulcer; however, they indicated that staff were applying barrier spray to a certain area of the resident's body as a nursing intervention and preventative measure.

A review of resident #013's care plan revealed a focus for pressure ulcer or potential pressure ulcer. The goal included to have the pressure ulcer on the resident's body improved or healed. The interventions included to have registered staff assess and apply dressings as per the Treatment Administration Record (TAR). There was no intervention for the use of a barrier spray.

During an interview with the Inspector, RPN #127 confirmed that the staff used the barrier spray, and that this was documented on the TAR. Inspector #603 and RPN #127 reviewed the TAR and confirmed that the barrier spray was not included on the TAR.

During an interview with the Inspector, PSW #115 revealed that one morning during the inspection, they decided not to use the barrier spray and used barrier cream instead to prevent skin breakdown. The use of barrier cream was not identified in resident #013's care plan. [s. 6. (1) (a)]

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

Inspector #603 observed resident #013's bed with two rotating assist bed rails. One bed rail was engaged in the guard position on the right side of bed and the left bed rail was in the transfer position.

During an interview with RN #114, they stated that the resident had one bed rail engaged on the right side of their bed to assist with bed mobility and that there was no need for the left bed rail.

A review of the resident's care plan revealed a focus for Personal Assistance Safety Device (PASD), use right bed rail to promote safety, security and assist with positioning. There was no mention of the left bed rail in the transfer position.

During an interview with the Inspector, the ADOC stated that the expectation was that only the bed rails that are engaged in the guard position are to be documented in the care plan. They further explained that they do not include the bed rails in the care plan if they are in the transfer position. [s. 6. (1) (c)]

3. During stage one of the inspection, Inspector #575 observed resident #002's bed with two rotating assist bed rails; one bed rail engaged in the guard position and one bed rail in the transfer position. On May 24, 2016, the resident was observed in bed with the left bed rail in the guard position and the right bed rail in the transfer position. On May 26, 2016, the resident was observed in bed with the right bed rail in the guard position and the left bed rail in the transfer position.

The resident's plan of care indicated that the resident required the use of one bed rail at

all times. The PASD assessment dated April 2016, indicated the use of one bed rail on the right side.

During an interview with the Inspector, RN #108 stated that bed rails (left or right) are determined by looking at the bed from the bottom of the bed (not anatomical to the resident).

During an interview with the Inspector, PSW #109 stated that the resident was to have the right bed rail engaged, however, PSW #118 stated that when applying bed rails, they would apply the bed rail to the resident's anatomical position (if right rail to be up, this would be on the resident's left side).

The Inspector observed different bed rails engaged with the resident in bed, the plan of care indicated the left bed rail but did not describe what side of the resident, two staff interviewed provided different directions. The plan of care also did not mention the use of the bed rail when in the transfer position. [s. 6. (1) (c)]

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

During the lunch dining service on May 16, 2016, Inspector #609 observed staff using an assistive device to provide fluids to resident #005.

A review of the plan of care and the dietary listing for resident #005 revealed no mention that staff were to use an assistive device to provide fluids to the resident.

During an interview with the FSM, they stated that it was the expectation that all assistive aids used by a resident to eat and drink were to be identified in the plan of care after an assessment for the aids was performed by the home's Registered Dietitian. The FSM confirmed to the Inspector that no assessment for the use of the assistive device and no revision to the resident's plan of care was performed before the assistive device was implemented for resident #005. [s. 6. (2)]

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

On May 24, 2016, Inspector #575 observed resident #007 in bed with two rotating assist bed rails in the transfer position.

The resident's plan of care indicated that the right bed rail was to be engaged in the guard position when the resident was in bed to promote participation in bed mobility.

During an interview with the Inspector, PSW #118 stated that the resident required the use of the right bed rail, however, they would put either bed rail up (in the transfer position) according to which way the resident was positioned.

During an interview with the Inspector, RN #113 confirmed that if the plan of care indicated only the right rail was to be applied, then that should be the only rail engaged in the guard position.

Progress notes for resident #007 were reviewed and revealed that on one occasion in May 2016, two bed rails were in guard position upon request from the resident. [s. 6. (7)]

6. During stage one of the inspection, resident #007 stated to Inspector #575 that they had dentures, however, they did not wear them.

Upon review of the resident's plan of care, it was revealed that the resident had been experiencing a medical condition and required medication. A physician ordered a medication four times per day for a period of 10 days. The medication was started on a certain date, however, approximately three days later, the TAR revealed that two doses (1630 and 2000 hours) were not provided. Progress notes revealed that the medication was not available.

During an interview with the Inspector, the ADOC confirmed that the RPN who administered the last available medication at 1130 hours should have called the pharmacy to advise of no tablets remaining for the next two scheduled doses. [s. 6. (7)]

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

During a record review conducted by Inspector #575, it was determined that resident #002 was hospitalized for a period of 20 days due to a medical incident. While in hospital, a device was inserted into the resident; upon return from hospital, it was determined that the device was not required, however it would remain in place.

A review of the resident's care plan revealed an intervention initiated two days after the resident returned from hospital, directed registered staff to monitor the resident's device daily at 1500 hours and document their assessment findings in the progress notes. Another intervention directed staff to monitor and measure the device and apply a certain medication twice per day. The TAR provided instructions for a dressing change to the resident's device, daily. These directions also provided for the application of the certain medication.

During an interview with the Inspector, RN #108 confirmed that the staff were not required to measure the device, that the application of the certain medication was done daily (not twice per day), and that staff did not monitor the device daily at 1500 hours. The RN confirmed that the resident's plan of care was not updated when the resident's care needs changed, and it did not reflect the current care needs of the resident. [s. 6. (10) (b)]

8. During stage one of the inspection, Inspector #575 conducted a record review which indicated that resident #003 had a pressure ulcer.

The Inspector reviewed the resident's health care record regarding skin and wound care. The initial wound assessment on Point Click Care (PCC) was completed in May 2016 and indicated the resident had a pressure ulcer. A progress note written nine days later, indicated that the pressure ulcer was healed. Three days after the progress note was written, indicating that the pressure ulcer was healed, the resident's care plan and TAR indicated that the resident had a pressure ulcer in the same area. In the care plan, the goal was to ensure that the pressure ulcer would not deteriorate, last revised on the same date the initial wound assessment was completed. The TAR indicated that staff were to complete a dressing change three times per week, initiated three days after the initial wound assessment was completed.

During an interview with the Inspector, RPN #120 stated that the pressure ulcer had now improved.

During an interview with the Inspector, RN #114 stated that weekly wound assessments were completed on PCC under the assessment tab. RN #114 confirmed that the most recent completed assessment was the initial assessment. The RN stated that if the wound was no longer the same, staff should have revised the resident's plan of care.

The home's policy titled, "Skin & Wound Care Management Protocol #VII-G-10", last

revised April 2016, stated that for resident's exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, registered staff are to initiate electronic weekly skin assessments and document in the plan of care any measures to promote healing. [s. 6. (10) (b)]

9. During the inspection, it was identified through the Minimum Data Set (MDS) that resident #013 had a worsening pressure ulcer.

Inspector #603 interviewed RN #114 who explained that resident #013 did not have any skin breakdown or a pressure ulcer.

A review of resident #013's care plan revealed a focus for pressure ulcer or potential pressure ulcer. The goal included to have the pressure ulcer improved or healed. The interventions included to have registered staff assess and apply dressings as per the TAR.

During an interview with the Inspector, RPN #127 stated that there was no dressing for a pressure ulcer on the TAR, and they also confirmed that the resident had not had a pressure ulcer for some time.

A review of the resident's TAR revealed that the last pressure ulcer was healed in January 2016. [s. 6. (10) (b)]

10. Inspector #627 reviewed a Critical Incident (CI) report submitted to the Director in August 2014. The CI was related to a fall that occurred three days prior, that caused a significant change in status to resident #024. The resident was sent to the hospital.

A review of the progress notes revealed that the resident also sustained a fall the day prior to the fall described in the CI report.

A review of the "Post Fall Huddle 2013" assessment form from the fall that occurred prior to the CI report, indicated that the resident was unable to answer the resident interview questions. A progress note revealed that the resident appeared confused, speech was mumbled, and they were difficult to understand.

The resident's plan of care in effect at the time of the fall failed to reveal any changes or update to the care plan to address the confusion.

During an interview, the ADOC confirmed that confusion after a fall should have been assessed and increased monitoring should have been included in the care plan and this was not done. [s. 6. (10) (b)]

11. During stage one of the inspection, Inspector #575 observed bed rail's engaged on resident #002's bed. Upon record review, the resident's plan of care indicated that in August 2015, the resident required the use of one bed rail engaged to assist with bed mobility. Resident #002 was hospitalized in February 2016, due to a medical incident that caused a significant change to the resident. Prior to the resident's hospitalization, a PASD assessment for the use of bed rails was completed in January 2016.

During an interview with the Inspector, the ADOC indicated that there was a process for determining the use of bed rails that included a three night monitoring of the resident while in bed, a PASD assessment, and an entrapment audit conducted by the maintenance department. The ADOC confirmed that if there was a change in the resident's bed or status of the resident, a new assessment should be completed. The ADOC confirmed that upon return from hospital, resident #002 did not receive a re-assessment regarding the use of bed rails. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 ensuring that resident #002 and #013's plan of care set out clear directions to staff and others who provide direct care to the resident, specifically regarding the use of bed rails and that care set out in the plan of care is provided to resident #007 and all residents as specified in the plans, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

During an interview with Inspector #603, resident #001 stated that the home was not clean, but indicated that it was not a new home.

On May 19, 2016, Inspector #603 observed a specific resident room which had accumulated dust on window sills, floor heat radiators, furniture, floors, and under the beds. Under the four beds, there was thick dust and debris such as crumbs, papers and sand.

During an interview with the Inspector, Housekeeping Aide (HA) #105 who was cleaning the unit, explained that the housekeeping staff have daily tasks. These daily tasks included cleaning every resident's room which involved the washrooms, mopping floors (including under the beds), and disposing of garbage. If at the end of the day, there was still time, the resident's room would be dusted, but that this rarely happens. The HA explained that a 'Housekeeping Tasks' log was kept on a daily basis, detailing what had been done. This log was used to identify which room needed to be dusted next. When the Inspector asked to see the task log, there was no form to be found. In this case, HA #105 explained that they had no idea which room needed to be dusted, nor did they think they had time to do any dusting.

The HA observed the specific room with Inspector #603 on May 19, 2016 and they confirmed that the room had not been dusted for a period of time as the dust was thick, grey, and caked on the furniture, heat radiators, and window sills. The HA also agreed that the floors under the beds had not been mopped as they were dusty and had

accumulated debris. A review of the housekeeping tasks for the previous day, indicated that the sweeping and mopping of the floor had been completed.

A review of the home's policy titled, "Departmental Functions - Housekeeping #XII-A-100.00", last revised January 2015, revealed that the principle functions for the Housekeeping Department were to maintain a safe and appealing environment which supports quality of life for residents and staff. The Environmental Services Manager will develop work routines to support an organized service that maintains a clean, sanitary, hazard-free, and attractive environment. [s. 15. (2) (a)]

2. During the initial tour of the home, Inspector #603 observed the home's three dining rooms and noted the following:

A.) On May 16, 2016, at 1100 hours, a specific dining room had three resident's participating in activities in a circle, with one attendant. The dining room's floor, tables, and chairs were not cleaned from the breakfast services. There was food, juice spillage, and medication cups on the floor. The dining room's lower windows were unclean. There were unclean clothing protectors on the window sills, and the window sills and heat radiators were dusty and had accumulated with food spillage.

B.) On May 16, 2016, at 1115 hours, another dining room had nine resident's participating in activities in the middle of the room. The dining room floor, tables, and chairs were not cleaned from the breakfast services. At 1118 hours, an interview with Dietary Aide (DA) #110 revealed that they did not have time to clean the tables from breakfast, until that time. The DA explained that normally, the DA's clean the tables, however, housekeeping staff would clean the floors and the chairs, if they had time.

C.) On May 16, 2016, at 1130 hours, the final dining room had several residents sitting at different tables. The dining room tables, chairs, stools, and floor were not cleaned. The window sills and radiators were dusty and the lower windows were unclean with food and fluid spillage. An interview with HA #111 confirmed the Inspector's observations and explained that there was not enough time to clean the tables, chairs, stools, windows, windows sills, and floor radiators. The HA explained that the stools and chairs were so "dirty" that they needed to be "spray washed" outside, but no one does it. The dining room floor was not cleaned because the housekeeping staff were not able to go into the dining room to clean, due to residents constantly occupying this room.

Inspector #603 interviewed the ES in one of the dining rooms. The Inspector explained

that between 1100 - 1130 hours, they observed the three dining room's floors, tables, chairs, stools, windows, window sills, heat radiators which were unclean. When the Inspector asked about the furnishings and equipment not being cleaned, the ES explained that tables, chairs, and stools are to be wiped down by the nursing staff. The home does a thorough cleaning of these furnishings and equipment, once or twice a year, where they are brought outside to do a pressure wash; otherwise, nursing staff do it as they go.

Further, the ES explained that the priority for housekeeping is to do a "hospital clean" which meant cleaning the resident's washrooms, garbage, bed rails, disinfecting the rooms, and spot mop the rooms as needed. The housekeeping staff would clean radiators, windows, and window sills, as needed. The ES confirmed that in the dining room observed by the Inspector at 1100 hours, the tables, chairs, stools, windows, window sills had not been cleaned for a period of time. [s. 15. (2) (a)]

3. On May 16, 2016, Inspector #609 observed a specific lunch dining service and noted that no tables were cleaned after the breakfast meal service finished or prior to the lunch meal service starting.

A review of the cleaning schedules for a week in May 2016, revealed three of 14 days or 21 per cent, were without any documentation that the tasks were completed. These tasks included washing and sanitizing the dining tables.

The cleaning schedules were reviewed with the FSM who confirmed through an internal investigation that the cleaning was completed, however, it was not documented.

A review of the home's dietary job routine schedule for one of the home areas revealed that staff were to follow the cleaning schedule and initial on the weekly cleaning schedule that the tasks were completed.

The FSM stated that it was the expectation of the home that the policies and procedures related to the cleaning of the dining room was complied with by staff.

The FSM confirmed that in the case of no documentation on three days of the cleaning schedule, the home was not in compliance. [s. 15. (2) (a)]

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 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 residents were protected from abuse by anyone.

Inspector #620 reviewed CI report submitted to the Director in July 2015. The CI alleged staff to resident physical abuse. The report indicated that PSW #122 handled resident #021 "roughly", causing physical injury to the resident. The report also indicated that PSW #122 had received discipline as a result of the home's investigation.

Inspector #620 reviewed the home's investigation notes related to this CI and identified that the home disciplined PSW #122.

According to the Ontario Regulation 79/10, the definition of physical abuse means "the use of physical force by anyone other than a resident that causes physical injury or pain".

Inspector #620 interviewed resident #021 who confirmed that they had been physically abused by a staff member of the home. The resident stated that they were very disturbed by the incident that had occurred and that since the incident that occurred they had received care from PSW #122; they did not want to, but had no choice.

A review of PSW #122's employee file revealed that they were hired by the home on a certain date. The documents further revealed that PSW #122's employment was contingent on, "receipt of a police criminal reference check free of criminal activities and satisfactory to Leisureworld's Police and Vulnerable Persons Records check policy". The documents also indicated that a third party (Back Check) was to be utilized to conduct

reference checks. A document contained in the file indicated that PSW #122 had provided the home with an criminal reference check dated approximately one year before they were hired.

Inspector #620 interviewed PSW #122 who stated that when they were hired they provided the home with a criminal reference check that they had acquired while in college. They stated that the reference check was not for vulnerable sectors, as it was not a requirement of their college. They stated that the home accepted the document.

During an interview with the Inspector, the Administrator confirmed that PSW #122 had been hired without a valid criminal reference check according to their policy in place at the time PSW #122 was hired. They stated that the document on file would not have been appropriate to allow PSW #122 to work within the facility as it was outdated. The home's policy at the time required the newly hired employee to utilize a third party to determine criminal reference suitability. The Administrator confirmed that no newly hired staff member was permitted to work within the facility until criminal reference suitability was determined. The Administrator confirmed that there was no indication that the home followed their previous policy on criminal reference suitability. The Administrator confirmed that PSW #122 would not be permitted to work within the home until they had secured a valid criminal reference check with a vulnerable sector screen.

Inspector #620 reviewed the home's investigation notes related to this CI and identified that the home became aware of the allegation of physical abuse on a certain day in July 2015 when it was reported to the ADOC; however, the home did not report the allegation of physical abuse to the Director until one day later.

Inspector #620 reviewed the home's policy titled, "Prevention of Abuse & Neglect of a Resident - #VII-G-10.00", last revised January 2015. The policy stated that staff who became aware of or suspected that an incident of abuse had occurred were to take immediate action in reporting the incident/allegation to the Director.

Inspector #620 interviewed the home's Administrator who confirmed that the home became aware of the allegation of physical abuse by PSW #122 toward resident #021 on a certain day in July 2015. The Administrator stated that it was the home's expectation that all incidences of suspected abuse were to be immediately reported to the Director and that this had not occurred.

A review of the home's investigation notes revealed that there was no indication that the

police had been notified of the physical abuse that caused injury to resident #021.

Inspector #620 reviewed the home's policy titled, "Prevention of Abuse & Neglect of a Resident - #VII-G-10.00", last revised January 2015. The policy stated it was the role of the Administrator and/or the Executive Director to, "immediately notify the Police of any alleged, suspected or witnessed incident of abuse or neglect of a resident which may constitute a criminal offence".

Inspector #620 interviewed the Administrator who confirmed that the physical abuse toward resident #021 by PSW #122, constituted an assault. The Administrator stated that if an incident of physical abuse occurs and causes injury, then they considered the abuse to be an assault. The Administrator confirmed that the police had not been notified of the suspicion of abuse that constituted a criminal offence.

The Inspector reviewed PSW #122's employee file and interviewed the ADOC who acknowledged that PSW #122 had a history of incidences of both abuse and neglect that had occurred in the home since 2014. The ADOC confirmed that following each incident, the home followed the same process of discipline and education. The ADOC stated that the staff member had to re-read the home's abuse policy, resident's rights policy, and job description. The ADOC stated that the home had substantiated that resident #021 had been physically abused by PSW #122 and that the abuse had caused injury. The ADOC confirmed that the home had not reassigned PSW #122 following the substantiation of the allegation and that as a result resident #021 was assigned to receive care by PSW #122. The ADOC confirmed that the resident had concerns about being cared for by PSW #122 following the incident of abuse, but the home made no effort to segregate PSW #122 from resident #021 and should have. The ADOC stated that the home's zero tolerance of abuse policy did not contain a procedure to ensure that the abuser would be separated from the alleging resident.

Inspector #620 interviewed the Administrator regarding the home's policy on zero tolerance of abuse. The Administrator stated that they were unable to find a statement of procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents. The Administrator confirmed that the procedure/interventions did not exist in the home's policy on zero tolerance of abuse and neglect of residents. [s. 19. (1)]

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. 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 a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident, immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #620 reviewed a CI report submitted to the Director on a certain date in July 2015. The CI alleged staff to resident physical abuse. The report indicated that PSW #122 handled resident #021 "roughly", causing injury to the resident. The report also indicated that PSW #122 had received discipline as a result of the home's investigation.

Inspector #620 reviewed the home's investigation notes related to this CI and identified that the home became aware of the allegation of physical abuse the day before the incident was reported to the Director.

Inspector #620 reviewed the home's policy titled, "Prevention of Abuse & Neglect of a Resident - #VII-G-10.00", last revised January 2015. The policy stated that staff who became aware of or suspected that an incident of abuse had occurred were to take immediate action in reporting the incident/allegation to the Director.

Inspector #620 interviewed the home's Administrator who confirmed that the home became aware of the allegation of physical abuse by PSW #122 toward resident #021 a day before it was reported to the Director. The Administrator stated that it was the home's expectation that all incidences of suspected abuse were to be immediately reported to the Director and that this had not occurred. [s. 24. (1)]

2. Inspector #620 reviewed a CI report submitted to the Director in May 2016. The CI alleged staff to resident physical abuse. The report indicated that PSW #122 caused injury to resident #026.

Inspector #620 conducted a review of the home's investigation notes which revealed that the home became aware of the allegation of physical abuse the day before the incident was reported to the Director.

Charge RN #128 documented the incident in a progress note on a certain day and completed an internal incident report; however, the home had not submitted a report to the Director until the next day.

Inspector #620 reviewed the home's policy titled, "Prevention of Abuse & Neglect of a Resident - #VII-G-10.00", last revised January 2015. The policy noted that the Charge RN was responsible for, "immediately reporting any of the following to the (MOHLTC) Director (with ED/Administrator or designate, if available)".

Inspector #620 interviewed the ADOC who confirmed that the Director had not been notified immediately of the allegation of physical abuse and that the investigation was on-going at this time. The ADOC confirmed that it was the home's expectation that the Director was to be notified immediately of all incidences of abuse, and that this had not occurred. [s. 24. (1)]

3. Inspector #620 reviewed a CI report submitted to the Director in March 2016. The CI alleged staff to resident physical and verbal abuse had occurred. The report indicated that PSW #139 handled resident #017 "roughly and spoke to the resident in a demeaning manner".

Inspector #620 reviewed the home's investigation which identified that the home became aware of the allegation of physical abuse the day before it was reported to the Director. The investigation documents contained a notice of discipline addressed to PSW #139.

Inspector #620 interviewed the Administrator who confirmed that it was the home's expectation that all incidents of alleged abuse were to be reported to the Director immediately. The Administrator stated that they reported the allegation of abuse a day after they became aware of the allegation. The Administrator confirmed that they did not report the allegation of abuse immediately. [s. 24. (1)]

4. Inspector #620 conducted a review of PSW #122's employee record and discovered PSW #122 was disciplined for an incident of verbal abuse toward resident #025. The letter identified that the home determined PSW #122 verbally abused resident #025.

The Inspector reviewed the Ministry of Health and Long-Term Care Critical Incident System, which did not contain a Critical Incident Report regarding this incident.

The Inspector interviewed the Administrator who stated that PSW #122 had verbally abused resident #025 and they confirmed that the incident had not been reported to the Director. [s. 24. (1) 2.]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspector #575 and #603 observed resident #002, #007, and #013 in bed with bed rails in use (Refer to WN #1 related to these resident's plans of care regarding bed rails). All three resident's had rotating assist bed rails.

The Inspector's reviewed the residents' plans of care which did not include a resident risk-benefit assessment. The plans of care included a PASD assessment form, however, this assessment did not include the use of transfer bed rails or a risk-benefit assessment. The home's policy was not clear and staff provided conflicting information regarding how resident's were assessed for bed rails and their bed system evaluated.

A memo from the Ministry of Health and Long-Term Care (MOHLTC) dated August 21, 2012 was sent to all Long-Term Care (LTC) Home Administrators indicating that all LTC homes should use the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards' as a best practice document in their homes. This document references the 'Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings' (CGA), as a prevailing practice for the assessing the use of bed rails.

The CGA document indicated that automatic use of bed rails may pose unwarranted hazards to resident safety and evaluation is needed to assess the relative risk of using the bed rail compared with not using it for an individual patient. The use of bed rails should be based on a residents' assessed needs, documented clearly and approved by the interdisciplinary team. Policy considerations included but not limited to a risk- benefit assessment that identified why other care interventions were not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the resident should be included in the residents plan of care. Additionally, a comprehensive assessment and identification of the residents' needs which include comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident should be included.

The CGA identified procedures including individualized resident assessments, sleeping environment assessments, and care planning guidelines. As well, Health Canada recommended that residents be re-assessed for risk of entrapment whenever there is a change in the patient's medication or physical condition.

A review of the home's policy titled, "Bed Rails #VII-E-10.20", last revised April 2016, indicated that the Director of Care or designate will in collaboration with Environmental Services, ensure that a resident's bed system was assessed for entrapment risks. The RN/RPN would assess the resident's need for the use of bed rails and for entrapment risk. The policy did not outline how this assessment was to be completed.

During an interview with Inspector #603, the Administrator and the ADOC indicated that the maintenance staff checked beds for entrapment risks and the nursing staff were to assess residents' needs for the use of bed rails using the "Restraint/PASD Assessment" form. Once the determination was made for the bed rail needs, there was no other bed system evaluation made for entrapment risk. The ADOC stated that the expectation was that only the bed rails that were engaged in the guard position were to be documented in the care plan. They further explained that they did not include the bed rails in the care plan if they are in the transfer position. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written hot weather related illness prevention and management plan that meets the needs of the residents was implemented when required to address the adverse effects on residents related to heat.

On May 18, 2016, during stage one of the inspection, Inspector #575 observed two specific resident rooms to be warm.

On May 24, 2016, at 1430 hours, Inspector #603 noted the outside temperature to be 27 degrees Celsius and inside the home to be warm. The following three room observations were conducted on one specific home area:

A) In the first room, the temperature reading was 29.3 degrees Celsius. Resident #007 was observed in the room and indicated they were warm. The room had one black out curtain and the other was missing.

B) In the second room, the temperature was 29.4 degrees Celcius and resident #014 was observed in bed with a long sleeve top, long pants and a fleece housecoat on. Resident #014 was indicated that they were warm.

C) In the third room, the temperature was 28.8 degrees Celcius and resident #022's visitor indicated the room was warm. The room's windows and window curtains were opened and the heat and sun were beaming in the room.

The home's policy titled, "Hot Weather-Management of Risk #VII-G-10.10", last reviewed

November 2015, was reviewed by Inspector #603. The policy provided "Hot Weather Protocols" which were to be implemented at the onset of summer, beginning with the May long weekend or end of May each year. If hot weather occurred prior to this date, the home would implement the Hot Weather Protocols at that time. The policy outline three levels of interventions: summertime practices, intervention alert, and emergency alert. For summertime practice, thresholds were outlined as relative humidity less than 50 per cent and the indoor temperature below 28 degrees Celcius. One intervention alert indicated relative humidity less than 50 per cent and the indoor temperature between 28 to 34 degrees Celcius. The Hot Weather Protocols for summertime included, but were not limited to the following: closing all curtained areas and windows between sunrise and sunset hours to minimize heat, monitor residents for signs and symptoms of heat exhaustion and heat stroke, maintain residents' hydration with increased fluid, dress residents in light clothing, and move residents into a cooling area. Inspector #603 noted that none of these interventions were implemented.

During an interview with Inspector #603, attending PSW #118 stated that the home was warm and that this was usual at this time of year. PSW #118 explained that when it was warm, the staff would try and keep the curtains closed, fans working, apply cool towels on the residents, or move the residents into the cooling areas (dining rooms and hallway lounges). PSW #118 confirmed that none of these interventions were implemented in any of the described rooms. PSW #118 entered the first room and noted the missing black out curtain and explained that it had been missing for some time. PSW #118 also noted resident #007 to be very warm and with no shirt on. The PSW later explained that they were going to move resident #007 into the cooling area and that they had requested that maintenance install the second black out curtain. Inspector #603 followed up with the Maintenance Supervisor (MS) who confirmed that the department had received notification of a missing curtain for the first room, unfortunately, there were none available to be installed.

During an interview with Inspector #603, charge RN #114 stated that they had not heard of resident rooms being warm, nor were they notified of interventions needed for high temperatures. For these reasons, RN #114 confirmed that no interventions or strategies were put in place to try and decrease the high temperatures in the residents' rooms.

During an interview with Inspector #603, the MS stated the maintenance staff were to document the hallway temperatures and humidity readings and this was started on May 24, 2016. The MS stated that the home does not conduct random resident room temperatures. However, the Inspector noted that the Air Temperature Log Form

indicated that staff were to document the indoor temperature, outdoor temperature and humidity reading daily from May 1 to September 30 in a random area.

Inspector #603 and the MS reviewed the Air Temperature Log Form for the specific home area, which identified an indoor temperature of 26.7 in the hallway and the humidity reading of 21. According to the MS, the home would not have alerted the staff regarding hot weather or interventions needed for resident care because the temperatures and humidity readings were not high enough. [s. 20. (1)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 162. Approval by licensee

Specifically failed to comply with the following:

s. 162. (3) Subject to subsections (4) and (5), the licensee shall, within five business days after receiving the request mentioned in clause (1) (b), do one of the following:
1. Give the appropriate placement co-ordinator the written notice required under subsection 44 (8) of the Act. O. Reg. 79/10, s. 162 (3).
2. If the licensee is withholding approval for the applicant's admission, give the written notice required under subsection 44 (9) of the Act to the persons mentioned in subsection 44 (10) of the Act. O. Reg. 79/10, s. 162 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that subject to subsections (4) and (5), within five business days after receiving the request mentioned in clause (1) (b), did one of the following:
1. Give the appropriate placement co-ordinator the written notice required under subsection 44 (8) of the Act.
2. If the licensee was withholding approval for the applicant's admission, give the written notice required under subsection 44 (9) of the Act to the persons mentioned in subsection 44 (10) of the Act.

Inspector #575 reviewed three complaints submitted to the Director regarding bed refusals for several applicants.

During an interview with the Community Care Access Center (CCAC) staff, the Administrator and upon review of records, the Inspector determined the following:

A.) Applicant #030 submitted an application for admission to the home in December 2014 and May 2015. The home refused admission via the Health Partner Gateway (HPG) online system 14 and seven days later respectively, however, no written notice outlining the details of the refusal were sent to the applicant, placement coordinator, or the Director. These responses were more than five business days.

B.) Applicant #031 submitted an application for admission to the home in November 2014. The home refused admission 10 days later via the HPG online system, however, no written notice outlining the details of the refusal were sent to the placement coordinator. The response was more than five business days.

C.) Six outstanding applications for admission to the home as of May 25, 2016:

-Applicant #030: New assessment completed March 2016, the home asked for more information in May 2016 (more than five business days);

-Applicant #032: January 2016 application, the home asked for more information on two occasions in January 2016, however, did not respond until May 2016 asking for more information (more than five business days);

-Applicant #033: January 2016 application, the home has not responded (more than five business days);

-Applicant #034: May 2016 application, written refusal notice was not sent until 16 days later (more than five business days);

-Applicant #035: May 2016 application, the home asked for more information 16 days later (more than five business days); and

-Applicant #036: May 2016 application, refused the same day, however, no written notice sent (more than five business days).

During an interview with the Administrator, they confirmed that the home did not meet the timeline of five business days as indicated above, and that they were not aware that they were required to send the written refusal notice to the placement coordinator. The Administrator stated that once an applicant was refused, if they applied again and were refused again, the home would not send out a new written notice outlining the details of the refusal. [s. 162. (3)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Findings/Faits saillants :

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

On May 17, 2016, during stage one of the inspection, Inspector #603 observed three resident rooms with loose electrical cords. The following were observed:

A.) Resident #011's room had loose electrical cords hanging against the lower walls under the windows. Resident #011 walked with their walker to the window and wheeled over one of the two cords.

B.) Resident #010's room had two long, loose electrical cords that were attached to a loose junction box. The end of the cords were curled up, sticking out, and dangling from the wall.

C.) Resident #006's room had one electrical cord that was looped, protruding out of the wall, and dangling loose on the floor, adjacent to the wall. Another independent loose cord was wrapped around the resident's floor fan three times and was not connected to any outlet. Resident #006 was observed wheeling over the cord with their wheelchair.

During an interview with the Maintenance Supervisor (MS), they stated that all of the cables were dealt with by a third party company (cable or phone) and these had "nothing to do with the work maintenance staff does". A clarification revealed that a third party (cable or phone) can be called upon by the residents or their families and services will be rendered to them. There was no sign in process for when these third party companies came into the home and the maintenance staff were not aware of any work being done, hence, there was no follow through on any work done by the third company. The MS confirmed that if the maintenance department knew about these cords, they would have removed them for safety reasons.

During an interview with the Inspector, the Administrator and the MS stated that the home did not require any third party companies to sign in when they came to do work to the home; however, there was a requirement for all contractors to sign in when they came to do work in the home. This process allowed for follow through by the maintenance staff. The MS explained that it was difficult to follow through on the safety and work done by a third company unless they knew when they were in the home. [s. 5.]

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 ensuring that the home is a safe and secure environment for its residents, including developing a process to ensure staff are aware when third party companies were completing work in the home, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspector #627 reviewed three CI reports submitted to the Director in regards to residents' falls.

A.) A review of the home's policy titled, "Falls Prevention #VII-G-30.00", last revised January 2015, revealed the following:

i) The Director of Care (DOC) or designate will:
-Determine a communication process by which residents at moderate or high risk for falling are easily identified to the entire care team.

During an interview with Inspector #627, the ADOC confirmed that there was no communication process by which residents at moderate or high risk for falling were easily identified.

ii) Falls Prevention Kit:
- A falls prevention kit should be accessible to the front line staff at all times.
- The kit was an accumulation of various items that could help prevent falls.
- Items in the kit may include: non-slip socks, chair and bed alarms, night light, hip protectors, reachers, crash mats, helmet, etc. Kit items were to be determined and maintained by the Falls Prevention Committee/ Resident Safety Committee.
-Staff were to inform the registered nurse if an item was introduced to the resident.
-Registered staff were to update the resident's plan of care to include the new interventions.

During interviews with the Inspector, front line/direct care staff stated that they did not know where the falls prevention kit was kept and none of the staff members were aware of such a kit (PSW #130, #131, #132, #134, #135, #136, #137, RPN #120, #124, #133, and #138).

During an interview with the Inspector, RN #113 stated there was "no kit per say", however, all of the articles in the policy were available to the home; some were available to PSWs, others were locked up.

During an interview with the Inspector, the ADOC confirmed that the kit items were available, but many were locked up. They explained that an RN would have to access it for the PSW's, therefore, it was not accessible to front line staff.

B.) A review of the "Leisureworld Falls Incident-Post Fall Huddle 2013" form completed in March 2016, and for April 2016, for two separate falls sustained by resident #027, revealed that Section F- Medication Status was left blank, on both occasions.

The home's policy titled, "Falls Prevention #VII-G-30.00", last revised January 2015, revealed that the post fall assessment was to include a thorough investigation of the fall incident including all contributing factors and that staff were to complete the electronic post fall assessment by using the Post Fall Huddle or Fall Incident Report.

A review of resident's Medication Administration Record (MAR) revealed that resident #027 was receiving a certain medication at bedtime.

During an interview with the Inspector, RN #103 confirmed that section F of the post fall assessment for the falls which occurred in March 2016, and April 2016, were not fully completed. The RN stated that they should have indicated that resident #027 received a certain medication and this was not done.

C.) A review of the assessments completed in the electronic document, for resident #027 and #029 failed to reveal a completed "Falls Risk Assessment".

The home's policy titled, "Falls Prevention #VII-G-30.00", last revised January 2015, revealed that staff were to complete the Falls Risk Assessment in the electronic documentation system at the following times:
-With 24 hours of admission or re-admission
-As triggered by the MDS Resident Assessment Protocol
-A significant change in status, i.e. when there is a physiological, functional, or cognitive change in status.

Resident #027 sustained a fall that caused a fracture which caused a significant change in status.

Resident #029 sustained a fall that caused a fracture which caused a significant change in status.

During an interview with the Inspector, the ADOC stated that the Fall Risk Assessment in the electronic documentation system was not available to the staff, therefore, it was not done. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the home's falls prevention policy is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including allergies, pain, risk of falls and other special needs.

Inspector #603 reviewed a CI report submitted to the Director in September 2015. The CI was related to a resident fall and significant change in status. According to the CI, no obvious injury was noted. The next day, the resident was noted to have increased pain. The resident was sent to the hospital and a fracture was confirmed. The CI also explained that the resident was at high risk for falls prior to this incident. They had previously fallen in April 2015, and in July 2015.

A review of the resident's care plan at the time of the incident, revealed no focus or interventions for risk for falls. There was no physiotherapy referral or risk for fall assessment completed after each fall in April 2015, and July 2015. Two physiotherapy referrals were sent in September 2015, before and after the third fall, but were not completed until October 2015 (fifteen days after the third fall in September 2015).

During an interview with the Inspector, the Physiotherapist confirmed that the two physiotherapy referrals sent in September 2015, were not completed.

During an interview with the Inspector, the ADOC confirmed that the CI indicated that the resident was at risk for falls prior to the incident, however, there was no indication of high risk for falls in the resident's plan of care although the resident had fallen twice before the last incident. [s. 26. (3) 10.]

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 ensuring that resident #028's plan of care is based on an interdisciplinary assessment with respect to health conditions including risk of falls, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan included a back-up plan for nursing and personal care staffing that addressed situations when staff, including the staff who provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work.

During stage one of the inspection, family members of resident #004, #005, and #008 reported to Inspectors that there were insufficient staff during outbreak situations, weekends, and during meals. In addition, Inspector #627 reviewed eight complaint logs submitted to the Director regarding staff shortages.

During an interview with the Inspector, the Administrator stated that the document titled, "Human Resource (HR) Plan", last revised January 2016, included the home's staffing plan.

The Inspector reviewed the HR Plan, which included a "Staffing Evaluation Plan", and revealed the compliment of all personnel including PSWs, RPNs and RNs. There was no written back-up plan for nursing and personal care staffing that addressed situations when staff could not come to work.

During an interview with the Administrator, they stated that if staff could not come to work, the scheduler or the RN called staff at home. The Administrator confirmed that the back-up plan was not in writing. [s. 31. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the written staffing plan includes a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

Inspector #603 observed nine resident rooms on May 17 and 18, 2016, and revealed eight or 88 per cent had unlabelled resident personal care items. These unlabelled personal care items included denture cups, toothpastes, combs, toothbrushes, shaving creams, deodorants, mouthwashes, basins and kidney basins.

During an interview with the Inspector, PSW #100 confirmed that the items should have been labelled. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to give persons described in subsection (10) a written notice setting out, the ground or grounds on which the licensee was withholding approval, a detailed explanation of the supporting facts, as they related to both the home and to the applicant's condition and requirements for care; an explanation of how the supporting facts justified the decision to withhold approval and contact information for the Director.

Inspector #575 reviewed two complaints submitted to the Director regarding admission referrals for two applicants, each refused by the home.

A.) Applicant #030 submitted an application for admission to the home in December 2014 and May 2015. The home refused admission via the HPG online system, however, no written notice outlining the details of the refusal were sent to the applicant, placement coordinator, or the Director.

A brief description of the reason for refusal in December 2014, was written by the DOC via the online referral site (HPG), used to communicate with the CCAC. The description stated that the most current Resident Assessment Instrument (RAI) notes indicated that the applicant had certain responsive behaviours, with no effective interventions and the staff lacked the expertise necessary to ensure the rights of the other residents in the home.

Inspector #575 reviewed the RAI notes from the assessment (used in the application for admission), which indicated that the applicant had responsive behaviours, however, the applicant was treated with certain medications with fair results.

A brief description of the reason for refusal in June 2015, was written by the DOC via HPG. The description stated that staff lacked the nursing expertise necessary to meet the applicants care requirements as they related to ensuring the rights of the other residents in the home. The decision was based on most current assessments that indicated the resident had certain responsive behaviours and medications had some effect, however, they did not respond to interventions to minimize this.

During an interview with the DOC, they confirmed that no letter was provided and the supporting facts as they related to both the home and to the applicants current condition and requirements for care were not explained.

B.) Applicant #031 submitted an application for admission to the home in November 2014. The home refused admission via the HPG online system in December 2014, however, no written notice outlining the details of the refusal were sent to the placement coordinator.

A written notice provided by the home addressed to the applicant's spouse was reviewed by the Inspector. The basis of refusal in the December 2014 letter was documented as the applicant's history of responsive behaviours. The letter further stated that based on this and history, they would be unable to ensure the right to a safe and secure home for other residents and staff lacked the nursing expertise to meet applicant #031's needs.

Inspector #575 reviewed the RAI assessment dated November 2014 (used in the application for admission). The RAI notes stated that the applicant was quiet on the unit, paced and slept in the afternoon and that they cooperated with staff and co-patients on the unit. The history of responsive behaviours was from 2012, before the applicant was admitted to hospital. The applicant had one instance of an inappropriate comment to a staff member, however, was re-directed effectively.

During an interview with the DOC, they stated that the letter described what they felt was the risk and that it was based on the applicant's history; however, they stated that it did not relate to describing the supporting facts and how they related to the applicant's requirements for care. [s. 44. (9)]

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 ensuring that if the licensee withholds approval for admission, the licensee shall give to the persons described in subsection (10) a written notice setting out the ground or grounds on which the licensee is withholding approval, a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care, an explanation of how the supporting facts justify the decision to withhold approval and contact information for the Director, to be implemented voluntarily.

WN #14: 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, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During a record review, Inspector #575 noted that resident #003 had a pressure ulcer. The initial wound assessment was completed on Point Click Care (PCC) under the assessment tab in May 2016. No further assessments were completed. A progress note dated nine days after the assessment was completed, indicated that the pressure ulcer was now healed.

During an interview with the Inspector, RN #114 confirmed that weekly wound assessments were completed on PCC under the assessment tab. RN #114 confirmed that the most recent completed assessment was the initial assessment; no weekly assessments were completed between in a period of nine days.

The home's policy titled, "Skin & Wound Care Management Protocol #VII-G-10", last revised April 2016 was reviewed by the Inspector. The policy stated that for residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, registered staff staff would initiate an electronic weekly skin assessment. [s. 50. (2) (b) (iv)]

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 ensuring that each resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

A complaint was submitted to the Director in March 2016, which alleged residents who were dependent on staff for nourishment were not being provided assistance to eat and drink during the snack services.

A.) On May 16, 2016, during the afternoon snack service, Inspector #609 observed resident #004 immobile, in a wheelchair, with a full cup of thickened fluid by the bedside. Thirty minutes later, the resident was transferred out of their room and none of the thickened fluid was provided to the resident.

Resident #004's plan of care was reviewed and indicated that the resident was at risk of fluid deficit, was totally dependent on staff for all their activities of daily living, including the intake for food and fluids.

During an interview with the Inspector, the Food Service Manager (FSM) confirmed that resident #004 should not have been left fluids at the bedside without staff to assist the resident.

B.) On May 20, 2016, at 1445 hours, Inspector #609 observed a full cup of fluids at the bedside of resident #020.

Resident #020's plan of care was reviewed and indicated that the resident was at high nutritional and fluid deficit risk and that they required assistance for food and fluid intake.

During an interview with the Inspector, PSW #119 confirmed that the full cup of fluids at the bedside of resident #020 was from the morning snack service, that it remained untouched and that the resident was not provided any assistance to drink it.

During an interview with the Inspector, the Administrator confirmed that it was the expectation of the home that all residents were provided the personal assistance required to eat and drink, that in the case of resident #004 and #020 they did not receive the assistance they required. [s. 73. (1) 9.]

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 ensuring that residents are provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, contained procedures and interventions to deal with persons who had abused or neglected or allegedly abused or neglected residents.

Inspector #620 reviewed a CI report submitted to the Director in July 2015. The CI alleged staff to resident physical abuse and that PSW #122 had received discipline as a result of the home's investigation.

The Inspector interviewed resident #021 who confirmed that they had been physically abused by a staff member of the home. The resident stated that since the incident, they had received care from PSW #122; they did not want to, but had no choice.

The Inspector reviewed the home's policy titled, "Prevention of Abuse & Neglect of a Resident - #VII-G-10.00". The policy did not contain any procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate.

The Inspector interviewed the Administrator regarding the home's policy on zero tolerance of abuse. The Administrator was asked to identify if the home's policy contained procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents. The Administrator stated that the policy did not include a statement of procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents. [s. 96. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, contains procedures and interventions to deal with persons who had abused or neglected or allegedly abused or neglected residents, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may have constitute a criminal offence.

Inspector #620 reviewed a CI report submiitted to the Director in July 2015. The CI alleged staff to resident physical abuse. The report indicated that PSW #122 caused injury to resident #021 and that PSW #122 had received discipline as a result of the home's investigation.

The Inspector reviewed the home's investigation notes related to this CI and identified that the home had disciplined PSW #122. The Inspector noted that there was no indication that the police had been notified of the physical abuse that caused injury to resident #021.

The Inspector reviewed the home's policy titled, "Prevention of Abuse & Neglect of a Resident - #VII-G-10.00". The policy stated it was the role of the Administrator and/or the Executive Director to, "immediately notify the Police of any alleged, suspected or witnessed incident of abuse or neglect of a resident which may constitute a criminal offence".

The Inspector interviewed the Administrator who stated that the physical abuse toward resident #021 by PSW #122 constituted an assault. The Administrator stated that if an incident of physical abuse occurred and caused an injury, then they considered the abuse to be an assault. The Administrator confirmed that the police had not been notified of the suspicion of abuse that constituted a criminal offence. [s. 98.]

2. Inspector #620 reviewed a CI report submitted to the Director in May 2016. The CI alleged staff to resident physical abuse. The report indicated that PSW #122 injured

resident #026.

The Inspector conducted a review home's investigation notes. Correspondence drafted by the Administrator revealed that they had indicated to the resident's spouse that they would call the police.

The Inspector interviewed the Administrator who stated that they had not yet contacted the police (nine days after the alleged incident) with regard to this CI. The Administrator stated that if an incident of physical abuse occurred and caused injury, then they considered the abuse to be an assault.

In a subsequent interview one day later, the Administrator stated that they had not yet notified the police of the allegation of physical abuse but that they intended to do so today, when they had an opportunity. [s. 98.]

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 ensuring that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may have constitute a criminal offence, to be implemented voluntarily.

WN #18: 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).

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, by the complaint being investigated and resolved where possible, and a response that complied with paragraph 3 was provided within 10 business days of the receipt of the complaint.

During the inspection, resident #019 approached Inspector #609 and stated that for over one month their television had not been working. The resident stated that they verbally complained multiple times to RN #103 and RN #125, but had not received a response from the home. Further clarification with the resident revealed that they could only get one channel on their television, that the television worked fine and that they paid for cable. The resident had last complained to RN #125 the same day.

In an interview with Inspector #609, RN #103 stated they were aware of the long-standing television complaints of resident #019, but thought that the resident wanted to fix an old tube television and that it was cost prohibitive. RN #103 provided no other assistance to the resident.

In an interview, RN #125 stated they were aware of the complaint made to them by resident #019, but thought it was related to fixing an old television. It was only after the complaint was again identified by the Inspector, did RN #125 state they were going to fill out a maintenance requisition.

A review of the home's policy titled, "Complaints - Response Guidelines", last revised January 2015, indicated that for verbal complaints staff were to obtain information about

the areas of concern, conduct and document an internal investigation, contact complainant, provide actions taken to resolve the complaint, ensure that departmental managers complete a complaint record within 24 hours and provide a written response to the complainant within 10 business days of a receipt of a verbal complaint that was not resolved in 24 hours.

During an interview with the Maintenance Supervisor the next day, they stated that they had addressed the issue with resident #019.

During an interview with the ADOC, they stated that it was the expectation of the home that verbal complaints were dealt with and resolved where possible and that staff were to have complied with the home's complaint policy. The ADOC confirmed that the long-standing verbal complaints related to the television of resident #019 were never investigated or resolved until brought forward by the Inspector. [s. 101. (1) 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 ensuring that every written or verbal complaint made to the licensee or a staff member concerning the care of resident #019 or the operation of the home is dealt with, by the complaint being investigated and resolved where possible, and a response that complies with paragraph 3 is provided within 10 business days of the receipt of the complaint, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure the written policies and protocols were developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices

Inspector #575 reviewed a CI report submitted to the Director in June 2015 regarding a missing fentanyl patch. The CI indicated that one resident was missing a fentanyl patch on their body.

During an interview with the Inspector, the ADOC stated that it was the home's expectation that staff were to check each resident with fentanyl patches applied each shift and sign on the electronic Medication Administration Record (eMAR).

The Administrator provided the inspector with two memo's dated December 3, 2014 and December 12, 2014. The memos outlined that all residents with fentanyl patches would have "checks" on their eMAR for patch placement. Staff were to ensure that patches were accounted for on each resident and eMAR signed accordingly. Staff were to document in the progress notes for each of these checks and report any discrepancies to the Charge RN.

Upon review of the resident's record, it was determined that the evening shift (2100) signed the eMAR indicating that a patch check was completed, however, there were no progress notes to support the check. It was not until the 0600 hours check the next day, that the progress notes indicated that the fentanyl patch was not found.

The Inspector reviewed the home's policy titled, "Safe Handling of Fentanyl Patches #04-07-20", last reviewed June 23, 2014, which indicated that staff were to check periodically

to ensure the patch was still in place, however, it did not indicate the home's current practice of checking each shift.

During an interview with the Inspector, the Administrator stated that the "Safe Handling of Fentanyl Patches #04-07-20" policy was a pharmacy specific policy and that the home would not update the pharmacy manual.

The inspector reviewed the home's Nursing Administration Manual which did not include direction related to the protocol for monitoring fentanyl patches.

During an interview with the Inspector, RN #114 stated that they were not aware of any written policy or procedure related to this process, however, they received a memo a few years ago. The RN stated that new staff would be advised of this process through orientation.

The home's policy and procedure's related to fentanyl patches was not updated to reflect the home's current practice [s. 114. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that written policies and protocols are developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that complied with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting).

During an interview with Inspector #575, RPN #127 stated that the refrigerator in the medication room was monitored for temperature and that it should be maintained between 2 - 8 degrees Celcius. The RPN stated that the temperatures were recorded twice per day and if they are not within range, staff were to record on the risk management sheet which was reviewed by the ADOC daily.

The Inspector reviewed the temperature log from May 21 - 24, 2016, for a specific home area refrigerator located in the medication room. The temperature log included the time the temperature was recorded, the current, minimum and maximum temperature, and actions taken. The inspector noted that on two occasions (May 21 and 22, 2016, in the afternoon) no temperature was recorded. On May 23, 2016, at 1520 hours, the current temperature recorded was 8.8 degrees Celcius and on May 24, 2016, at 1510 hours, the current temperature was 10.7 degrees Celcius. On all dates, the maximum temperature ranged from 9.1 to 12.3 degrees Celcius. No actions taken were recorded.

During an interview with the Inspector, the ADOC stated that when staff notice the temperature of the refrigerator was not within the desired temperature range, they were to report to the office or notify on shift report and make the RN aware. The ADOC

confirmed they expect the temperatures to be recorded twice per day and that they were not notified when the temperatures were not within range.

The following medications were stored in the specific home area medication refrigerator with the following manufacturers instructions:

-Lantus insulin- stored in a refrigerator between 2-8 degrees; if freezes or overheats should be
discarded (x 2 boxes)
-NovoMix 30 penfil insulin and Novorapid Flextouch- store between 2-10 degrees (x 2 boxes each)
-Levemir Flextouch and Humulin R insulin- store 2-8 degrees (x2 boxes and x4 boxes)
-Latanoprost eye drops- store between 2-8 degrees (x4 boxes)

The home's policy titled, "Inventory Control - Storage of Refrigerated Medications #02-06 -12", last reviewed June 23, 2014, indicated that thermo-labile products must be stored in the refrigerator and are to be stored properly according to manufacturers specifications. Refrigerators must be able to maintain a temperature of 2 - 8 degrees Celcius and provided for troubleshooting when having difficulty maintaining temperatures within range. None of these interventions were implemented. [s. 129. (1) (a) (iv)]

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 ensuring that drugs are stored in an area or medication cart that complies with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting), to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

During the inspection, Inspector #609 heard resident #012 on four separate occasions with episodes of responsive behaviours directed towards PSWs who were attempting to provide care. When the staff left the room after attempting care, resident #012 was heard exhibiting responsive behaviours in their room.

Resident #012 resided in a room with three other residents. During the four responsive behaviour episodes, one or more roommates were present in the room.

During an interview with PSW #104, they stated that although there had not been an altercation between resident #012 and any of their roommates, the resident had been known to have specific responsive behaviours of a threatening nature.

A review of the plan of care for resident #012 revealed no mention of any interventions to assist other residents at risk of harm as a result of the responsive behaviours of resident #012, especially those of the three roommates in proximity to the resident during these episodes.

During an interview with the ADOC, they stated that it was the expectation of the home that residents at risk of harm as a result of the responsive behaviours of a resident, interventions were developed and implemented to protect the other residents. The ADOC confirmed that no interventions were in place to protect the other residents of the home from the responsive behaviours of resident #012. [s. 55. (a)]

WN #22: 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 substitute decision-maker, if any, and any other person specified by the resident, were 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.

Inspector #620 reviewed a CI submitted to the Director in May 2016 which alleged staff to resident physical abuse. The report indicated that PSW #122 injured resident #026.

Inspector #620 conducted a review of the home's investigation notes which revealed that RN #128 became aware of the allegation of physical abuse on a certain day in May 2016. The document also indicated that RN #103 notified the SDM approximately 12 hours after RN #128 became aware of the allegation.

Inspector #620 reviewed the home's policy titled, "Prevention of Abuse & Neglect of a Resident - #VII-G-10.00". The policy stated that staff who became aware of or suspected that an incident of abuse occurred, were to notify the resident's SDM immediately.

Inspector #620 interviewed the ADOC who confirmed that the resident's SDM had not been contacted until one day following the home's awareness of the allegation of physical abuse. The ADOC confirmed that it was the home's expectation that the SDM was to be notified immediately of all incidences of abuse, and that this had not occurred. [s. 97. (1) (a)]

WN #23: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written report included actions taken in response to the incident, including the outcome or current status of the individual or individuals who were involved in the incident.

Inspector #603 reviewed a CI report submitted to the Director in February 2016. The CI referred to a respiratory outbreak declared by the home. On April 22, 2016, the Director requested the home to amend the CI with updates, including when the outbreak was declared over. As of May 25, 2016, there was no update provided.

An review of documentation given by the ADOC revealed that the respiratory outbreak was declared over on April 18, 2016.

A review of the home's current policy titled, "Reporting of Communicable Disease and Outbreaks #IX-B-10.00", revealed that the Executive Director/Administrator or designate will notify the MOHLTC via the CIS reporting portal, once the communicable disease/outbreak is resolved. In this case, the home did not notify the Director with the date that the outbreak was declared over. [s. 107. (4) 3.]

Issued on this 15th day of September, 2016

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) :	LINDSAY DYRDA (575), ALAIN PLANTE (620), CHAD CAMPS (609), SYLVIE BYRNES (627), SYLVIE LAVICTOIRE (603)
Inspection No. / No de l'inspection :	2016_332575_0014
Log No. / Registre no:	011366-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 2, 2016
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	Waters Edge Care Community 401 WILLIAM STREET, NORTH BAY, ON, P1A-1X5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	RUTH GAUTHIER

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

To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, 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. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall:

Develop and implement a process to ensure that when a resident's care needs change, or care set out in the plan of care is no longer necessary, the resident's plan of care is reviewed and revised.

Grounds / Motifs :

1. During stage one of the inspection, Inspector #575 observed bed rail's engaged on resident #002's bed. Upon record review, the resident's plan of care indicated that in August 2015, the resident required the use of one bed rail engaged to assist with bed mobility. Resident #002 was hospitalized in February 2016, due to a medical incident that caused a significant change to the resident. Prior to the resident's hospitalization, a PASD assessment for the use of bed rails was completed in January 2016.

During an interview with the Inspector, the ADOC indicated that there was a process for determining the use of bed rails that included a three night monitoring of the resident while in bed, a PASD assessment, and an entrapment audit conducted by the maintenance department. The ADOC confirmed that if there was a change in the resident's bed or status of the resident, a new assessment should be completed. The ADOC confirmed that upon return from hospital, resident #002 did not receive a re-assessment regarding the use of bed

rails.
(575)

2. Inspector #627 reviewed a Critical Incident (CI) report submitted to the Director in August 2014. The CI was related to a fall that occurred three days prior, that caused a significant change in status to resident #024. The resident was sent to the hospital.

A review of the progress notes revealed that the resident also sustained a fall the day prior to the fall described in the CI report.

A review of the "Post Fall Huddle 2013" assessment form from the fall that occurred prior to the CI report, indicated that the resident was unable to answer the resident interview questions. A progress note revealed that the resident appeared confused, speech was mumbled, and they were difficult to understand.

The resident's plan of care in effect at the time of the fall failed to reveal any changes or update to the care plan to address the confusion.

During an interview, the ADOC confirmed that confusion after a fall should have been assessed and increased monitoring should have been included in the care plan and this was not done.
(627)

3. During the inspection, it was identified through the Minimum Data Set (MDS) that resident #013 had a worsening pressure ulcer.

Inspector #603 interviewed RN #114 who explained that resident #013 did not have any skin breakdown or a pressure ulcer.

A review of resident #013's care plan revealed a focus for pressure ulcer or potential pressure ulcer. The goal included to have the pressure ulcer improved or healed. The interventions included to have registered staff assess and apply dressings as per the TAR.

During an interview with the Inspector, RPN #127 stated that there was no dressing for a pressure ulcer on the TAR, and they also confirmed that the resident had not had a pressure ulcer for some time.

A review of the resident's TAR revealed that the last pressure ulcer was healed in January 2016.
(603)

4. During stage one of the inspection, Inspector #575 conducted a record review which indicated that resident #003 had a pressure ulcer.

The Inspector reviewed the resident's health care record regarding skin and wound care. The initial wound assessment on Point Click Care (PCC) was completed in May 2016 and indicated the resident had a pressure ulcer. A progress note written nine days later, indicated that the pressure ulcer was healed. Three days after the progress note was written, indicating that the pressure ulcer was healed, the resident's care plan and TAR indicated that the resident had a pressure ulcer in the same area. In the care plan, the goal was to ensure that the pressure ulcer would not deteriorate, last revised on the same date the initial wound assessment was completed. The TAR indicated that staff were to complete a dressing change three times per week, initiated three days after the initial wound assessment was completed.

During an interview with the Inspector, RPN #120 stated that the pressure ulcer had now improved.

During an interview with the Inspector, RN #114 stated that weekly wound assessments were completed on PCC under the assessment tab. RN #114 confirmed that the most recent completed assessment was the initial assessment. The RN stated that if the wound was no longer the same, staff should have revised the resident's plan of care.

The home's policy titled, "Skin & Wound Care Management Protocol #VII-G-10", last revised April 2016, stated that for resident's exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, registered staff are to initiate electronic weekly skin assessments and document in the plan of care any measures to promote healing.
(575)

5. During a record review conducted by Inspector #575, it was determined that resident #002 was hospitalized for a period of 20 days due to a medical incident. While in hospital, a device was inserted into the resident; upon return from

hospital, it was determined that the device was not required, however it would remain in place.

A review of the resident's care plan revealed an intervention initiated two days after the resident returned from hospital, directed registered staff to monitor the resident's device daily at 1500 hours and document their assessment findings in the progress notes. Another intervention directed staff to monitor and measure the device and apply a certain medication twice per day. The TAR provided instructions for a dressing change to the resident's device, daily. These directions also provided for the application of the certain medication.

During an interview with the Inspector, RN #108 confirmed that the staff were not required to measure the device, that the application of the certain medication was done daily (not twice per day), and that staff did not monitor the device daily at 1500 hours. The RN confirmed that the resident's plan of care was not updated when the resident's care needs changed, and it did not reflect the current care needs of the resident.

The decision to issue this compliance order was based on the severity, scope and compliance history. The severity was determined to be potential for actual harm, with a pattern affecting four resident's. Despite previous non-compliance (NC) within s. 6 of the legislation during inspections #2015_273580_0003, #2015_391603_0013, #2014_376594_0018, #2014_246196_0008, and #2013_211106_0039, NC continues in this area of legislation. (575)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2016

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

Order / Ordre :

The licensee shall:

1. Develop a schedule to ensure dusting is completed in all resident rooms and common areas.

2. Develop and implement an auditing process to ensure that residents' rooms and common areas of the home are kept clean and sanitary, and ensuring that the daily cleaning tasks, are completed as required.

3. Develop and implement an auditing process to ensure that dining areas, including but not limited to dining room tables, chairs and stools, are cleaned after each meal service.

Grounds / Motifs :

1. The licensee has failed to ensure that its furnishings and equipment were kept clean and sanitary.

On May 16, 2016, Inspector #609 observed a specific lunch dining service and noted that no tables were cleaned after the breakfast meal service finished or prior to the lunch meal service starting.

A review of the cleaning schedules for a week in May 2016, revealed three of 14 days or 21 per cent, were without any documentation that the tasks were

completed. These tasks included washing and sanitizing the dining tables.

The cleaning schedules were reviewed with the FSM who confirmed through an internal investigation that the cleaning was completed, however, it was not documented.

A review of the home's dietary job routine schedule for one of the home areas revealed that staff were to follow the cleaning schedule and initial on the weekly cleaning schedule that the tasks were completed.

The FSM stated that it was the expectation of the home that the policies and procedures related to the cleaning of the dining room was complied with by staff.

The FSM confirmed that in the case of no documentation on three days of the cleaning schedule, the home was not in compliance. (575)

2. During the initial tour of the home, Inspector #603 observed the home's three dining rooms and noted the following:

A.) On May 16, 2016, at 1100 hours, a specific dining room had three resident's participating in activities in a circle, with one attendant. The dining room's floor, tables, and chairs were not cleaned from the breakfast services. There was food, juice spillage, and medication cups on the floor. The dining room's lower windows were unclean. There were unclean clothing protectors on the window sills, and the window sills and heat radiators were dusty and had accumulated with food spillage.

B.) On May 16, 2016, at 1115 hours, another dining room had nine resident's participating in activities in the middle of the room. The dining room floor, tables, and chairs were not cleaned from the breakfast services. At 1118 hours, an interview with Dietary Aide (DA) #110 revealed that they did not have time to clean the tables from breakfast, until that time. The DA explained that normally, the DA's clean the tables, however, housekeeping staff would clean the floors and the chairs, if they had time.

C.) On May 16, 2016, at 1130 hours, the final dining room had several residents sitting at different tables. The dining room tables, chairs, stools, and floor were not cleaned. The window sills and radiators were dusty and the lower windows

were unclean with food and fluid spillage. An interview with HA #111 confirmed the Inspector's observations and explained that there was not enough time to clean the tables, chairs, stools, windows, windows sills, and floor radiators. The HA explained that the stools and chairs were so "dirty" that they needed to be "spray washed" outside, but no one does it. The dining room floor was not cleaned because the housekeeping staff were not able to go into the dining room to clean, due to residents constantly occupying this room.

Inspector #603 interviewed the ES in one of the dining rooms. The Inspector explained that between 1100 - 1130 hours, they observed the three dining room's floors, tables, chairs, stools, windows, window sills, heat radiators which were unclean. When the Inspector asked about the furnishings and equipment not being cleaned, the ES explained that tables, chairs, and stools are to be wiped down by the nursing staff. The ES explained that the home does a thorough cleaning of these furnishings and equipment, once or twice a year, where they are brought outside to do a pressure wash; otherwise, nursing staff do it as they go.

Further, the ES explained that the priority for housekeeping is to do a "hospital clean" which meant cleaning the resident's washrooms, garbage, bed rails, disinfecting the rooms, and spot mop the rooms as needed. The housekeeping staff would clean radiators, windows, and window sills, as needed. The ES confirmed that in the dining room observed by the Inspector at 1100 hours, the tables, chairs, stools, windows, window sills had not been cleaned for a period of time. (603)

3. During an interview with Inspector #603, resident #001 stated that the home was not clean, but indicated that it was not a new home.

On May 19, 2016, Inspector #603 observed a specific resident room which had accumulated dust on window sills, floor heat radiators, furniture, floors, and under the beds. Under the four beds, there was thick dust and debris such as crumbs, papers and sand.

During an interview with the Inspector, Housekeeping Aide (HA) #105 who was cleaning the unit, explained that the housekeeping staff have daily tasks. These daily tasks included cleaning every resident's room which involved the washrooms, mopping floors (including under the beds), and disposing of garbage. If at the end of the day, there was still time, the resident's room would

be dusted, but that this rarely happens. The HA explained that a 'Housekeeping Tasks' log was kept on a daily basis, detailing what had been done. This log was used to identify which room needed to be dusted next. When the inspector asked to see the task log, there was no form to be found. In this case, HA #105 explained that they had no idea which room needed to be dusted, nor did they think they had time to do any dusting.

The HA observed the specific room with Inspector #603 on May 19, 2016 and they confirmed that the room had not been dusted for a period of time as the dust was thick, grey, and caked on the furniture, heat radiators, and window sills. The HA also agreed that the floors under the beds had not been mopped as they were dusty and had accumulated debris. A review of the housekeeping tasks for the previous day, indicated that the sweeping and mopping of the floor had been completed.

A review of the home's policy titled, "Departmental Functions - Housekeeping #XII-A-100.00", last revised January 2015, revealed that the principle functions for the Housekeeping Department were to maintain a safe and appealing environment which supports quality of life for residents and staff. The Environmental Services Manager will develop work routines to support an organized service that maintains a clean, sanitary, hazard-free, and attractive environment.

The decision to issue this compliance order was based on the severity, scope and compliance history. Several areas of the home were observed unclean, which was determined to have a widespread effect on the well-being and quality of life of all residents. During inspection #2014_246196_0008, a Voluntary Plan of Correction was issued pursuant to the LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) c, the licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. During inspection #2015_391603_0013, a Written Notification was issued pursuant to the LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) a and s. 15. (2) c. Despite previous NC, NC continues within this area of the legislation. (603)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

1. Develop and implement a system to ensure that that when an allegation of abuse or neglect is reported, that may constitute a criminal offence, the appropriate police force is immediately notified.

2. Review and revise the home's policy titled, "Prevention of Abuse & Neglect of a Resident -#VII-G-10.00" to ensure that there are effective procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected.

3. Ensure when an allegation of abuse is reported, no resident has any unnecessary contact with the potential perpetrator, until any investigation is completed.

4. Ensure the Director is notified immediately when a person who has reasonable grounds to suspect that abuse of a resident has occurred or may occur that resulted in harm or risk of harm to the resident.

5. Re-educate all staff on the revised policy, and maintain a training record.

Grounds / Motifs :

1. The licensee has failed to ensure residents were protected from abuse by anyone.

Inspector #620 reviewed CI report submitted to the Director in July 2015. The CI alleged staff to resident physical abuse. The report indicated that PSW #122

handled resident #021 "roughly", causing physical injury to the resident. The report also indicated that PSW #122 had received discipline as a result of the home's investigation.

Inspector #620 reviewed the home's investigation notes related to this CI and identified that the home disciplined PSW #122.

According to the Ontario Regulation 79/10, the definition of physical abuse means "the use of physical force by anyone other than a resident that causes physical injury or pain".

Inspector #620 interviewed resident #021 who confirmed that they had been physically abused by a staff member of the home. The resident stated that they were very disturbed by the incident that had occurred and that since the incident that occurred they had received care from PSW #122; they did not want to, but had no choice.

A review of PSW #122's employee file revealed that they were hired by the home on a certain date. The documents further revealed that PSW #122's employment was contingent on, "receipt of a police criminal reference check free of criminal activities and satisfactory to Leisureworld's Police and Vulnerable Persons Records check policy". The documents also indicated that a third party (Back Check) was to be utilized to conduct reference checks. A document contained in the file indicated that PSW #122 had provided the home with an criminal reference check dated approximately one year before they were hired.

Inspector #620 interviewed PSW #122 who stated that when they were hired they provided the home with a criminal reference check that they had acquired while in college. They stated that the reference check was not for vulnerable sectors, as it was not a requirement of their college. They stated that the home accepted the document.

During an interview with the Inspector, the Administrator confirmed that PSW #122 had been hired without a valid criminal reference check according to their policy in place at the time PSW #122 was hired. They stated that the document on file would not have been appropriate to allow PSW #122 to work within the facility as it was outdated. The home's policy at the time required the newly hired employee to utilize a third party to determine criminal reference suitability. The Administrator confirmed that no newly hired staff member was permitted to

work within the facility until criminal reference suitability was determined. The Administrator confirmed that there was no indication that the home followed their previous policy on criminal reference suitability. The Administrator confirmed that PSW #122 would not be permitted to work within the home until they had secured a valid criminal reference check with a vulnerable sector screen.

Inspector #620 reviewed the home's investigation notes related to this CI and identified that the home became aware of the allegation of physical abuse on a certain day in July 2015 when it was reported to the ADOC; however, the home did not report the allegation of physical abuse to the Director until one day later.

Inspector #620 reviewed the home's policy titled, "Prevention of Abuse & Neglect of a Resident - #VII-G-10.00", last revised January 2015. The policy stated that staff who became aware of or suspected that an incident of abuse had occurred were to take immediate action in reporting the incident/allegation to the Director.

Inspector #620 interviewed the home's Administrator who confirmed that the home became aware of the allegation of physical abuse by PSW #122 toward resident #021 on a certain day in July 2015. The Administrator stated that it was the home's expectation that all incidences of suspected abuse were to be immediately reported to the Director and that this had not occurred.

A review of the home's investigation notes revealed that there was no indication that the police had been notified of the physical abuse that caused injury to resident #021.

Inspector #620 reviewed the home's policy titled, "Prevention of Abuse & Neglect of a Resident - #VII-G-10.00", last revised January 2015. The policy stated it was the role of the Administrator and/or the Executive Director to, "immediately notify the Police of any alleged, suspected or witnessed incident of abuse or neglect of a resident which may constitute a criminal offence".

Inspector #620 interviewed the Administrator who confirmed that the physical abuse toward resident #021 by PSW #122, constituted an assault. The Administrator stated that if an incident of physical abuse occurs and causes injury, then they considered the abuse to be an assault. The Administrator confirmed that the police had not been notified of the suspicion of abuse that constituted a criminal offence.

The Inspector reviewed PSW #122's employee file and interviewed the ADOC who acknowledged that PSW #122 had a history of incidences of both abuse and neglect that had occurred in the home since 2014. The ADOC confirmed that following each incident, the home followed the same process of discipline and education. The ADOC stated that the staff member had to re-read the home's abuse policy, resident's rights policy, and job description. The ADOC stated that the home had substantiated that resident #021 had been physically abused by PSW #122 and that the abuse had caused injury. The ADOC confirmed that the home had not reassigned PSW #122 following the substantiation of the allegation and that as a result resident #021 was assigned to receive care by PSW #122. The ADOC confirmed that the resident had concerns about being cared for by PSW #122 following the incident of abuse, but the home made no effort to segregate PSW #122 from resident #021 and should have. The ADOC stated that the home's zero tolerance of abuse policy did not contain a procedure to ensure that the abuser would be separated from the alleging resident.

Inspector #620 interviewed the Administrator regarding the home's policy on zero tolerance of abuse. The Administrator stated that they were unable to find a statement of procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents. The Administrator confirmed that the procedure/interventions did not exist in the home's policy on zero tolerance of abuse and neglect of residents.

The decision to issue this compliance order was based on the severity, scope and compliance history. Actual harm occurred to one resident which affected the resident's safety, well-being and quality of life. A previous Written Notification was issued during inspection #2014_283544_0007. (620)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 04, 2016

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 : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee shall develop and implement a process to ensure that a person who has reasonable grounds to suspect that 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 has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director.

Grounds / Motifs :

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

Inspector #620 reviewed a CI report submitted to the Director in March 2016. The CI alleged staff to resident physical and verbal abuse had occurred. The report indicated that PSW #139 handled resident #017 "roughly and spoke to the resident in a demeaning manner".

Inspector #620 reviewed the home's investigation which identified that the home became aware of the allegation of physical abuse the day before it was reported to the Director. The investigation documents contained a notice of discipline

addressed to PSW #139.

Inspector #620 interviewed the Administrator who confirmed that it was the home's expectation that all incidents of alleged abuse were to be reported to the Director immediately. The Administrator stated that they reported the allegation of abuse a day after they became aware of the allegation. The Administrator confirmed that they did not report the allegation of abuse immediately. (620)

2. Inspector #620 reviewed a CI report submitted to the Director in May 2016. The CI alleged staff to resident physical abuse. The report indicated that PSW #122 caused injury to resident #026.

Inspector #620 conducted a review of the home's investigation notes which revealed that the home became aware of the allegation of physical abuse the day before the incident was reported to the Director.

Charge RN #128 documented the incident in a progress note on a certain day and completed an internal incident report; however, the home had not submitted a report to the Director until the next day.

Inspector #620 reviewed the home's policy titled, "Prevention of Abuse & Neglect of a Resident - #VII-G-10.00", last revised January 2015. The policy noted that the Charge RN was responsible for, "immediately reporting any of the following to the (MOHLTC) Director (with ED/Administrator or designate, if available)".

Inspector #620 interviewed the ADOC who confirmed that the Director had not been notified immediately of the allegation of physical abuse and that the investigation was on-going at this time. The ADOC confirmed that it was the home's expectation that the Director was to be notified immediately of all incidences of abuse, and that this had not occurred.
(620)

3. Inspector #620 reviewed a CI report submitted to the Director on a certain date in July 2015. The CI alleged staff to resident physical abuse. The report indicated that PSW #122 handled resident #021 "roughly", causing injury to the resident. The report also indicated that PSW #122 had received discipline as a result of the home's investigation.

Inspector #620 reviewed the home's investigation notes related to this CI and identified that the home became aware of the allegation of physical abuse the day before the incident was reported to the Director.

Inspector #620 reviewed the home's policy titled, "Prevention of Abuse & Neglect of a Resident - #VII-G-10.00", last revised January 2015. The policy stated that staff who became aware of or suspected that an incident of abuse had occurred were to take immediate action in reporting the incident/allegation to the Director.

Inspector #620 interviewed the home's Administrator who confirmed that the home became aware of the allegation of physical abuse by PSW #122 toward resident #021 a day before it was reported to the Director. The Administrator stated that it was the home's expectation that all incidences of suspected abuse were to be immediately reported to the Director and that this had not occurred. (620)

4. Inspector #620 conducted a review of PSW #122's employee record and discovered PSW #122 was disciplined for an incident of verbal abuse toward resident #025. The letter identified that the home determined PSW #122 verbally abused resident #025.

The Inspector reviewed the Ministry of Health and Long-Term Care Critical Incident System, which did not contain a Critical Incident Report regarding this incident.

The Inspector interviewed the Administrator who stated that PSW #122 had verbally abused resident #025 and they confirmed that the incident had not been reported to the Director.

The decision to issue this compliance order was based on the severity, scope and compliance history. Four CI's reviewed related to staff to resident abuse were reported late, which was determined to be widespread with the potential to cause actual harm to residents. Despite previous non-compliance (NC) issued on three separate occasions as Voluntary Plans of Correction during inspections #2015_273580_0003, #2015_391603_0013, 2014_376594_0017, NC continues within this area of the legislation. (620)

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 15, 2016

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

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

The licensee shall:

1. Develop an interdisciplinary team to conduct bed rail assessments.

2. Develop/modify assessment tools following the Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings document, including an individualized resident assessment, sleeping environment assessment, and risk-benefit assessment.

3. Conduct bed system assessments for all residents who require the use of bed rails, following the Health Canada guidance document, and re-assess when there is a change in condition;

4.) Train direct care staff on the use of bed rails and bed systems, including, zones of entrapment;

5.) Maintain a record of the resident assessment and bed system assessment;

6.) Update/revise the home's policy with any changes made;

7.) Ensure the resident's #002, #007, and #013's plans of care provides clear direction to all direct care staff.

Grounds / Motifs :

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

Inspector #575 and #603 observed resident #002, #007, and #013 in bed with bed rails in use (Refer to WN #1 related to these resident's plans of care regarding bed rails). All three resident's had rotating assist bed rails.

The Inspector's reviewed the residents' plans of care which did not include a resident risk-benefit assessment. The plans of care included a PASD assessment form, however, this assessment did not include the use of transfer bed rails or a risk-benefit assessment. The home's policy was not clear and staff provided conflicting information regarding how resident's were assessed for bed rails and their bed system evaluated.

A memo from the Ministry of Health and Long-Term Care (MOHLTC) dated August 21, 2012 was sent to all Long-Term Care (LTC) Home Administrators indicating that all LTC homes should use the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards' as a best practice document in their homes. This document references the 'Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings' (CGA), as a prevailing practice for the assessing the use of bed rails.

The CGA document indicated that automatic use of bed rails may pose unwarranted hazards to resident safety and evaluation is needed to assess the relative risk of using the bed rail compared with not using it for an individual patient. The use of bed rails should be based on a residents' assessed needs, documented clearly and approved by the interdisciplinary team. Policy considerations included but not limited to a risk- benefit assessment that identified why other care interventions were not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the resident should be included in the residents plan of care. Additionally, a comprehensive assessment and identification of the residents' needs which include comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident should be included.

The CGA identified procedures including individualized resident assessments, sleeping environment assessments, and care planning guidelines. As well, Health Canada recommended that residents be re-assessed for risk of entrapment whenever there is a change in the patient's medication or physical condition.

A review of the home's policy titled, "Bed Rails #VII-E-10.20", last revised April 2016, indicated that the Director of Care or designate will in collaboration with Environmental Services, ensure that a resident's bed system was assessed for entrapment risks. The RN/RPN would assess the resident's need for the use of

bed rails and for entrapment risk. The policy did not outline how this assessment was to be completed.

During an interview with Inspector #603, the Administrator and the ADOC indicated that the maintenance staff checked beds for entrapment risks and the nursing staff were to assess residents' needs for the use of bed rails using the "Restraint/PASD Assessment" form. Once the determination was made for the bed rail needs, there was no other bed system evaluation made for entrapment risk. The ADOC stated that the expectation was that only the bed rails that were engaged in the guard position were to be documented in the care plan. They further explained that they did not include the bed rails in the care plan if they are in the transfer position.

The decision to issue this compliance order was based on the severity and scope. It was determined that there was potential for actual harm to the health, safety and well-being of all residents who require the use of bed rails. No previous compliance history related to this area of the legislation had been previously issued. (575)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 04, 2016

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 : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Order / Ordre :

The licensee shall:

1. Perform a comprehensive review of the home's policy titled, "Hot Weather-Management of Risk #VII-G-10.10", and ensure the policy clearly outline's processes and procedure's related to extreme heat and hot weather management.

2. Implement preventative measures when required.

3. Ensure air temperatures and humidity readings are taken in resident rooms.

4. Educate all staff on the revised policy.

5. Develop an auditing process to ensure all staff are complying with the home's policy.

Grounds / Motifs :

1. The licensee has failed to ensure that the written hot weather related illness prevention and management plan that meets the needs of the residents was implemented when required to address the adverse effects on residents related to heat.

On May 18, 2016, during stage one of the inspection, Inspector #575 observed two specific resident rooms to be warm.

On May 24, 2016, at 1430 hours, Inspector #603 noted the outside temperature to be 27 degrees Celsius and inside the home to be warm. The following three room observations were conducted on a specific home area:

A) In the first room, the temperature reading was 29.3 degrees Celsius. Resident #007 was observed in the room and indicated they were warm. The room had one black out curtain and the other was missing.

B) In the second room, the temperature was 29.4 degrees Celcius and resident #014 was observed in bed with a long sleeve top, long pants and a fleece housecoat on. Resident #014 was indicated that they were warm.

C) In the third room, the temperature was 28.8 degrees Celcius and resident #022's visitor indicated the room was warm. The room's windows and window curtains were opened and the heat and sun were beaming in the room.

The home's policy titled, "Hot Weather-Management of Risk #VII-G-10.10", last reviewed November 2015, was reviewed by Inspector #603. The policy provided "Hot Weather Protocols" which were to be implemented at the onset of summer, beginning with the May long weekend or end of May each year. If hot weather occurred prior to this date, the home would implement the Hot Weather Protocols at that time. The policy outline three levels of interventions: summertime practices, intervention alert, and emergency alert. For summertime practice, thresholds were outlined as relative humidity less than 50 per cent and the indoor temperature below 28 degrees Celcius. One intervention alert indicated relative humidity less than 50 per cent and the indoor temperature between 28 to 34 degrees Celcius. The Hot Weather Protocols for summertime included, but were not limited to the following: closing all curtained areas and windows between sunrise and sunset hours to minimize heat, monitor residents for signs and symptoms of heat exhaustion and heat stroke, maintain residents' hydration with increased fluid, dress residents in light clothing, and move residents into a cooling area. Inspector #603 noted that none of these interventions were implemented.

During an interview with Inspector #603, attending PSW #118 stated that the home was warm and that this was usual at this time of year. PSW #118 explained that when it was warm, the staff would try and keep the curtains closed, fans working, apply cool towels on the residents, or move the residents

into the cooling areas (dining rooms and hallway lounges). PSW #118 confirmed that none of these interventions were implemented in any of the described rooms. PSW #118 entered the first room and noted the missing black out curtain and explained that it had been missing for some time. PSW #118 also noted resident #007 to be very warm and with no shirt on. The PSW later explained that they were going to move resident #007 into the cooling area and that they had requested that maintenance install the second black out curtain. Inspector #603 followed up with the Maintenance Supervisor (MS) who confirmed that the department had received notification of a missing curtain for the first room, unfortunately, there were none available to be installed.

During an interview with Inspector #603, charge RN #114 stated that they had not heard of resident rooms being warm, nor were they notified of interventions needed for high temperatures. For these reasons, RN #114 confirmed that no interventions or strategies were put in place to try and decrease the high temperatures in the residents' rooms.

During an interview with Inspector #603, the MS stated the maintenance staff were to document the hallway temperatures and humidity readings and this was started on May 24, 2016. The MS stated that the home does not conduct random resident room temperatures. However, the Inspector noted that the Air Temperature Log Form indicated that staff were to document the indoor temperature, outdoor temperature and humidity reading daily from May 1 to September 30 in a random area.

Inspector #603 and the MS reviewed the Air Temperature Log Form for the specific home area, which identified an indoor temperature of 26.7 in the hallway and the humidity reading of 21. According to the MS, the home would not have alerted the staff regarding hot weather or interventions needed for resident care because the temperatures and humidity readings were not high enough.

The decision to issue this compliance order was based on the severity, scope and compliance history. Actual risk to the health, safety and well-being of all resident's was determined. No previous compliance history related to this area of the legislation had been previously issued. (603)

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 30, 2016

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 : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 162. (3) Subject to subsections (4) and (5), the licensee shall, within five business days after receiving the request mentioned in clause (1) (b), do one of the following:
1. Give the appropriate placement co-ordinator the written notice required under subsection 44 (8) of the Act.
2. If the licensee is withholding approval for the applicant's admission, give the written notice required under subsection 44 (9) of the Act to the persons mentioned in subsection 44 (10) of the Act. O. Reg. 79/10, s. 162 (3).

Order / Ordre :

The licensee shall develop and implement a process to ensure that within five business days after receiving a request to give or withhold approval, one of the following is completed:

a) The appropriate placement co-ordinator is provided the written notice under subsection 44 (8) of the Act; or

b) If the licensee is withholding approval for the applicant's admission, give the written notice required under subsection 44 (9) of the Act to the applicant, the Director, and the appropriate placement co-ordinator.

Grounds / Motifs :

1. The licensee has failed to ensure that subject to subsections (4) and (5), within five business days after receiving the request mentioned in clause (1) (b), did one of the following:
1. Give the appropriate placement co-ordinator the written notice required under subsection 44 (8) of the Act.
2. If the licensee was withholding approval for the applicant's admission, give the written notice required under subsection 44 (9) of the Act to the persons mentioned in subsection 44 (10) of the Act.

Inspector #575 reviewed three complaints submitted to the Director regarding

bed refusals for several applicants.

During an interview with the Community Care Access Center (CCAC) staff, the Administrator and upon review of records, the Inspector determined the following:

A.) Applicant #030 submitted an application for admission to the home in December 2014 and May 2015. The home refused admission via the Health Partner Gateway (HPG) online system 14 and seven days later respectively, however, no written notice outlining the details of the refusal were sent to the applicant, placement coordinator, or the Director. These responses were more than five business days.

B.) Applicant #031 submitted an application for admission to the home in November 2014. The home refused admission 10 days later, via the HPG online system, however, no written notice outlining the details of the refusal were sent to the placement coordinator. The response was more than five business days.

C.) Six outstanding applications for admission to the home as of May 25, 2016:

-Applicant #030: New assessment completed in March 2016, the home asked for more information in May 2016 (more than five business days);

-Applicant #032: January 2016 application, the home asked for more information on two occasions in January 2016, however, did not respond until May 2016 asking for more information (more than five business days);

-Applicant #033: January 2016 application, the home has not responded (more than five business days);

-Applicant #034: May 2016 application, written refusal notice was not sent until 16 days later (more than five business days);

-Applicant #035: May 2016 application, the home asked for more information 16 days later (more than five business days); and

-Applicant #036: May 2016 application, refused the same day, however, no written notice sent (more than five business days);

During an interview with the Administrator, they confirmed that the home did not meet the timeline of five business days as indicated above, and that they were not aware that they were required to send the written refusal notice to the placement coordinator. The Administrator stated that once an applicant was refused, if they applied again and were refused again, the home would not send out a new written notice outlining the details of the refusal.

The decision to issue this compliance order was based on the severity, scope and the compliance history. The severity was determined to be minimum risk as it did not affect the resident's currently residing in the home, however the scope was determined to be widespread, as the non-compliance (NC) represents a systemic failure that affected or has the potential to affect a large number applicants. This pattern of inaction, affects the clients awaiting approval or rejection for admission to the home. No previous compliance history related to this area of the legislation had been previously issued. (575)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 2nd day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lindsay Dyrda

Service Area Office /
Bureau régional de services : Sudbury Service Area Office