Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 24, 2019	2019_795735_0020	011336-19, 012080-19, 012649-19, 012928-19, 014938-19	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 2) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Maitland Manor
290 South Street GODERICH ON N7A 4G6

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

KRISTAL PITTER (735), KIM BYBERG (729)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 12-16, 19-22, and 26, 2019

Complaint Inspection # 2019_795735_0019 was conducted in conjunction with this inspection.

Janet M Evans, Inspector #659, was part of this inspection.

The following intakes were completed in this Critical Incident System inspection:

Log # 011336-19, AH IL-67384-AH, CI # 0965-000028-19 related to responsive behaviour.
Log # 012080-19, CI # 0965-000031-19 related to falls prevention.
Log # 012649-19, AH IL-67874-AH, CI # 0965-000035-19 related to responsive behaviour.
Log # 012928-19, AH IL-67988-AH, CI # 0965-000036-19 related to medication.
Log # 014938-19, AH IL-68893-AH, CI # 0965-000043-19 related to responsive behaviour.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Interim Office Manager (IOM), Skin and Wound Lead, Behavioural Support Ontario (BSO) Lead, Registered Nurses (RN), a Registered Nursing Student, Registered Practical Nurses (RPN), Dietary Aides, Personal Support Workers (PSW), Health Care Aides (HCA), Agency Director, Agency Office Administrator, Agency Personal Support Worker, complainants, and residents.

The inspectors also toured resident home areas, observed resident care provision, resident staff interaction, dining services, reviewed relevant residents' clinical records, and relevant policies and procedures pertaining to the inspection.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Responsive Behaviours
Training and Orientation

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a

resident in the home unless the drug was prescribed for that resident.

A) A Critical Incident (CI) report submitted to the Ministry of Long-Term Care (MOLTC) stated that an identified resident received medications that were prescribed for another resident. The identified resident's health status changed, and they were transferred to the hospital for assessment.

The home's Medication Incident Report (MIR) stated an Agency Registered Practical Nurse (RPN) discovered their medication error four hours after the error was made. Eight medications prescribed for another resident were given in error to the identified resident. In addition, the identified resident received their own scheduled medications.

A Registered Nurse (RN) shared that the Agency RPN notified them of the medication error. The RN called the Physician who provided no further direction. The RN monitored the identified resident throughout the night, and assisted with sending them to the hospital when their medical condition changed.

The Director of Care (DOC) shared that Agency registered staff were buddied up to work with the home's registered staff, and were provided orientation on medication administration. The DOC was not able to provide confirmation that the identified Agency RPN received orientation to the home's policies and procedures. The DOC shared that the identified Agency RPN was removed from duty in the home and did not return.

B) A review of the MIR for another identified resident stated that the resident was given pain medication by mouth. When a RN signed the Medication Administration Record (MAR), they noticed that the same medication had been given two and a half hours earlier.

The identified resident's physician ordered the medication to be administered every night as needed for pain. A review of the resident's MAR identified that this resident received pain medication by mouth on a specified date and time, and a second dose of the same medication by mouth two and a half hours later.

The RN stated in the MIR that they had not checked the MAR prior to giving the medication. The RN said they reported the medication error, notified the identified resident of their error, and monitored them throughout the night.

The DOC shared that they reviewed the medication incident with the RN, they were

aware of their medication error, and indicated education was provided to them.

C) A review of the MIR for another identified resident documented that on a specified date and time, the resident was administered an extra dose of medication by mouth by a RN. The MIR stated the RN accidentally gave the medication, and did not realize it had already been given by the RPN on duty.

The identified resident's physician had ordered the medication by mouth at bedtime. The resident's MAR showed the medication was signed as administered by the RPN at a specified date and time, and the MIR stated it was also given two hours and 50 minutes later that same day.

Progress notes in Point Click Care (PCC) identified that the RN documented that the resident requested the medication and the RN administered the medication without acknowledging it was already given earlier.

The DOC stated that they discussed the medication incident with the RN, and they acknowledged their error.

The licensee has failed to ensure that no drug was used by or administered to three residents unless the drug was prescribed for that resident. [s. 131. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that Agency RNs and Agency RPNs received orientation

training before performing their responsibilities.

A) A CI report submitted to the MOLTC stated that on a specified date an identified resident received medications that were prescribed for another resident. The resident's health status changed and they were transferred to the hospital for assessment.

The home's MIR stated an Agency RPN administered eight medications prescribed for another resident to the identified resident, in addition to the identified resident's own medications.

The Interim Office Manager (IOM) shared that the Agency RPN was provided orientation with the home's RPN, and worked independently on specified dates.

A review of the home's orientation file for agency staff members did not contain any orientation documentation provided by the home to the Agency RPN.

The Agency Director shared that the Agency RPN received orientation with their company prior to being sent to the home.

The document Health Service Nursing Orientation Agreement identified the date the orientation agreement was completed by the Agency RPN, 21 days after the Agency RPN commenced work at the home. The orientation document did not include specific polices or procedures for the home.

The DOC shared that it was the DOC or the charge nurse that provided orientation to agency staff, and agency staff then completed the home's orientation checklist. The DOC stated they did not have any orientation documentation or checklists completed for the Agency RPN.

B) A review of the home's orientation file for agency staff members, identified that there was no orientation documentation for two Agency RNs.

The document Health Service Nursing Orientation Agreement signed by the two Agency RNs on specified dates, did not include specific policies or procedures that had been reviewed for the home.

The DOC stated they had not provided orientation, nor was there any orientation documentation or checklists completed by the two Agency RNs.

The licensee failed to ensure that an Agency RPN and two Agency RNs were provided with orientation training before performing their responsibilities in the home. [s. 76. (2)]

2. The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in skin and wound care.

A complaint was received by the MOLTC related to skin and wound care.

Review of progress note documentation for an identified resident showed an entry written by an Agency RPN on a specified date related to altered skin integrity for the identified resident.

There was no skin/wound referral, Treatment Administration Record (TAR) documentation, or documented assessment for the wound.

The Skin and Wound Lead stated that when a wound was identified, there should be an initial skin and wound assessment in PCC, and a progress note completed along with a referral to the Skin and Wound Lead.

Review of a blank copy of the Orientation Checklist for Registered staff showed a checklist for skin care which stated that the following should be completed as part of orientation: TARs overview; new wound documentation required (referral); assessment in PCC; add to doctors orders for generation of TAR; weekly assessment; and assessments required for new admits and readmits.

The identified Agency RPN had orientation shifts with the home on four specified dates.

The identified Agency RPN stated that they had not been provided with training related to skin and wound care from the home. Their orientation training consisted of an orientation to working on the unit, and a review of falls and the routines of the unit. They received an orientation package from the home that they were to review with a checklist to complete, but they had not reviewed the package nor had they returned the checklist to the home.

The DOC stated their process for training agency staff was to bring them in and give them an orientation package, and review the priorities of the package with them prior to their working on the unit. The agency staff would then follow an RPN for one to two shifts,

or more if required. The DOC stated that agency staff were shown a policy manual so they could access any policy to review. They left the staff to complete the review themselves, and there was no follow-up to ensure it had been done. (659)

The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in skin and wound care. [s. 76. (7) 6.]

Additional Required Actions:

CO # - 002 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 to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in skin and wound care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) A CI report submitted to the MOLTC stated that two residents had an altercation on a specified date and time without injury. The CI report indicated that 30 minute safety checks were put in place for the remainder of the evening.

No documentation of completed 30 minute safety checks on the specified date were located for one of the residents. (735)

B) A CI report submitted to the MOLTC stated that two residents had an altercation on a specified date and time, with no injuries noted following completed head to toe assessments. The CI report indicated that 15 minute safety checks were put in place.

There were ongoing verbal responsive behaviours between the two residents for several weeks with Behaviour Support Ontario (BSO) involvement in care.

The home implemented a wanderer's checklist that staff completed to monitor the safety and location of the two residents.

The document titled "Wanderer's fifteen-minute checklist" on specified dates for one of the residents was unclear. The checklist was also incomplete as there was no documentation for specified time frames.

The document titled "Wanderer's fifteen-minute checklist" on specified dates for the other resident was incomplete as there was no documentation every 15 minutes for specified time frames. (735)

C) A CI report submitted to the MOLTC stated that two residents had an altercation on a specified date that resulted in an injury to one of the residents.

One of the identified residents had a history of wandering throughout the home and into other residents' personal space that caused other responsive behaviours when they were redirected. The home implemented a wanderer's checklist that staff completed to monitor the safety and location of this resident.

The document titled "Wanderer's hourly checklist" on specified dates, stated that the location of the identified resident was only checked nightly by staff for a certain period of time. There was no documentation completed by staff for a specific time frame.

The home implemented a second checklist titled "Wanderer's fifteen-minute checklist" on specified dates, after an altercation occurred between two residents. There was no documentation that one of the residents was checked for a specified date and time frame. The checklist for a specified date was not completed for specified time frames. The altercation between these two residents resulted in an injury to one of the residents.

The PSW / BSO Lead stated that the wanderer's checklist was implemented at the discretion of the registered staff, and registered staff determined the frequency and duration for which safety checks were to be completed. The PSW / BSO Lead shared that registered staff were responsible to ensure that safety checks on the wanderer's checklist were completed. The PSW / BSO Lead shared that resident safety checks on the wanderer's checklist should have been completed for three residents on specified dates and during specified time frames. (729, 735)

An RPN shared that one of the resident's wanderer's checklists were not completed during an eight day period of time, and they should have been. (729)

The ED stated that it was the home's expectation that safety checks be completed when resident altercations occurred. The ED stated that the safety check documentation for one of the residents could not be located for a specified date; and acknowledged that safety check documentation on specified dates for two residents was unclear and incomplete. (735)

D) A complaint was received by the MOLTC related to skin and wound care for an identified resident.

Review of the clinical record for the identified resident showed the resident had frequent altered skin integrity.

Review of the progress notes for specified dates, did not show evidence of an entry for treatment in relation to the identified resident's altered skin integrity.

Review of the TAR for specified dates, did not show documentation of a treatment completed for the identified resident's wound.

A RN stated that they had worked on specified dates, and that they changed a dressing for the identified resident after the resident had been put to bed. They stated that they had not completed any documentation related to this. They acknowledged they made an error and should have completed documentation for the identified resident's wound treatment. (659)

The licensee failed to ensure that safety checks, an intervention with respect to three residents under the Responsive Behaviours program, were documented on specified

dates. In addition, the licensee failed to ensure that any actions taken with respect to another identified resident, under the skin and wound program, were documented on specified dates. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions, and the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 2nd day of October, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	KRISTAL PITTER (735), KIM BYBERG (729)
Inspection No. / No de l’inspection :	2019_795735_0020
Log No. / No de registre :	011336-19, 012080-19, 012649-19, 012928-19, 014938-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 24, 2019
Licensee / Titulaire de permis :	CVH (No. 2) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Maitland Manor 290 South Street, GODERICH, ON, N7A-4G6
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Tanya Adams

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To CVH (No. 2) 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 :

O.Reg 79/10, s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Order / Ordre :

The licensee must be compliant with s. 131(1) of the regulations.

Specifically, the licensee must:

A) Ensure that any drug used by or administered to resident #007, #008, #014, and any other resident in the home has been prescribed for the resident.

Grounds / Motifs :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug was prescribed for that resident.

A) A Critical Incident (CI) report submitted to the Ministry of Long-Term Care (MOLTC) stated that an identified resident received medications that were prescribed for another resident. The identified resident's health status changed, and they were transferred to the hospital for assessment.

The home's Medication Incident Report (MIR) stated an Agency Registered Practical Nurse (RPN) discovered their medication error four hours after the error was made. Eight medications prescribed for another resident were given in error to the identified resident. In addition, the identified resident received their own scheduled medications.

A Registered Nurse (RN) shared that the Agency RPN notified them of the medication error. The RN called the Physician who provided no further direction. The RN monitored the identified resident throughout the night, and assisted with sending them to the hospital when their medical condition changed.

The Director of Care (DOC) shared that Agency registered staff were buddied up to work with the home's registered staff, and were provided orientation on medication administration. The DOC was not able to provide confirmation that the identified Agency RPN received orientation to the home's policies and procedures. The DOC shared that the identified Agency RPN was removed from duty in the home and did not return.

B) A review of the MIR for another identified resident stated that the resident was given pain medication by mouth. When a RN signed the Medication Administration Record (MAR), they noticed that the same medication was given two and a half hours earlier.

The identified resident's physician ordered the medication to be administered every night as needed for pain. A review of the resident's MAR identified that this resident received pain medication by mouth on a specified date and time, and a second dose of the same medication by mouth two and a half hours later.

The RN stated in the MIR that they had not checked the MAR prior to giving the medication. The RN said they reported the medication error, notified the identified resident of their error, and monitored them throughout the night.

The DOC shared that they reviewed the medication incident with the RN, they were aware of their medication error, and indicated education was provided to them.

C) A review of the MIR for another identified resident documented that on a specified date and time, the resident was administered an extra dose of medication by mouth by a RN. The MIR stated the RN accidentally gave the medication, and did not realize it had already been given by the RPN on duty.

The identified resident's physician had ordered the medication by mouth at bedtime. The resident's MAR showed the medication was signed as administered by the RPN at a specified date and time, and the MIR stated it was also given two hours and 50 minutes later that same day.

Progress notes in Point Click Care (PCC) identified that the RN documented that the resident requested the medication and the RN administered the medication

without acknowledging it was already given earlier.

The DOC stated that they discussed the medication incident with the RN, and they acknowledged their error.

The licensee has failed to ensure that no drug was used by or administered to three residents unless the drug was prescribed for that resident.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the residents. The scope of the issue was a level 3, widespread, as it had the potential to affect three out of three LTCH residents. The home had a level 2 history, with previous noncompliance (NC) in the last 36 months to a different subsection of the LTCHA that included:

Voluntary Plan of Correction (VPC) issued February 11, 2019 (2018_601532_0026)

(729)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

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

Order / Ordre :

The licensee must be compliant with s. 76 (2) 10 of the LTCHA.

Specifically, the licensee must:

a) Ensure that Agency RPN #120, Agency RN #124, Agency RN #125, and any other agency or home staff, receive required training / education specific to the home's medication administration policies as outlined by s. 76. (2) of the LTCHA, prior to performing their duties.

b) Ensure that records are kept in the home of the completed training.

Grounds / Motifs :

1. The licensee failed to ensure that Agency RNs and Agency RPNs received orientation training before performing their responsibilities.

A) A CI report submitted to the MOLTC stated that on a specified date an identified resident received medications that were prescribed for another resident. The resident's health status changed and they were transferred to the hospital for assessment.

The home's MIR stated an Agency RPN administered eight medications prescribed for another resident to the identified resident, in addition to the identified resident's own medications.

The Interim Office Manager (IOM) shared that the Agency RPN was provided orientation with the home's RPN, and worked independently on specified dates.

A review of the home's orientation file for agency staff members did not contain any orientation documentation provided by the home to the Agency RPN.

The Agency Director shared that the Agency RPN received orientation with their company prior to being sent to the home.

The document Health Service Nursing Orientation Agreement identified the date the orientation agreement was completed by the Agency RPN, 21 days after the Agency RPN commenced work at the home. The orientation document did not include specific polices or procedures for the home.

The DOC shared that it was the DOC or the charge nurse that provided orientation to agency staff, and agency staff then completed the home's orientation checklist. The DOC stated they did not have any orientation documentation or checklists completed for the Agency RPN.

B) A review of the home's orientation file for agency staff members, identified that there was no orientation documentation for two Agency RNs.

The document Health Service Nursing Orientation Agreement signed by the two Agency RNs on specified dates, did not include specific policies or procedures that had been reviewed for the home.

The DOC stated they had not provided orientation, nor was there any orientation

documentation or checklists completed by the two Agency RNs.

The licensee failed to ensure that an Agency RPN and two Agency RNs were provided with orientation training before performing their responsibilities in the home.

The severity of this issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was a level 3, widespread, as three out of three staff had not been trained prior to performing their duties. The home had a level 2 history, with previous noncompliance (NC) in the last 36 months to a different subsection of the LTCHA. (729)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 24th day of September, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kristal Pitter

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