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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 23, 2015	2015_380593_0024	011811-15, 012461-15	Follow up

Licensee/Titulaire de permis

584482 ONTARIO INC
689 YONGE STREET MIDLAND ON L4R 2E1

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

MANITOULIN LODGE
3 MAIN STREET P. O. BOX 648 GORE BAY ON P0P 1H0

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

GILLIAN CHAMBERLIN (593)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): September 22 - 25, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nutrition Manager, Registered Nursing Staff, Registered Dietitian, Activation Staff, Personal Support Workers (PSW) and residents.

The inspector also observed the provision of care and services to residents, observed staff to resident interactions, observed resident to resident interactions, observed residents' environment, reviewed resident health care records, reviewed staff training records, reviewed staff schedules and reviewed home policies.

The following Inspection Protocols were used during this inspection:
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **0 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #003	2015_331595_0004	593
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #004	2015_331595_0004	593
O.Reg 79/10 s. 31. (3)	CO #005	2015_331595_0004	593
O.Reg 79/10 s. 53. (4)	CO #007	2015_331595_0004	593
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2015_331595_0004	593

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

Findings/Faits saillants :

1. The licensee has failed to ensure the care set out in the plan of care was provided to resident #005 as specified in the plan, specifically related to the use of a pressure relieving device.

On seven occasions during the inspection, Inspector #593 observed resident #005 in bed with a pressure relieving device set at setting number A.

A review of resident #005's current care plan found that the resident had altered skin integrity in two areas caused by prolonged pressure and one of the interventions to manage this was a pressure relieving device set at setting number B.

A review of resident #005's current Kardex found an intervention documented as "ensure pressure relieving device setting is at number B".

During an interview with Inspector #593 on September 24, 2015, #S-101 reported that the resident does use a pressure relieving device because of their altered skin integrity. They confirmed that there was a specific setting for the pressure relieving device and this would be in the resident's care plan. #S-101 further reported that restorative care have assessed the resident and they determined the setting required for the pressure relieving device.

During an interview with Inspector #593 on September 24, 2015, #S-102 reported that the resident used a pressure relieving device. They added that the setting of this device was based on the resident's weight, they were unsure exactly what the setting was however they would never need to adjust this setting.

During an interview with Inspector #593 on September 25, 2015, #S-101 reported that

resident #005 used a pressure relieving device which is part of their skin care. They further reported that there was a particular setting that the device was to be set at, however they were unsure exactly what this was. #S-101 added that the setting is based on the resident's weight and their weight had been stable so the setting would not need to change.

During an interview with Inspector #593 on September 24, 2015, #S-103 confirmed that they completed the pressure relieving device assessment for resident #005. They reported that the purpose of the device was that it relieved pressure from the areas where the resident had altered skin integrity. The pressure relieving device was supposed to help with preventing and healing of altered skin integrity. #S-103 further reported that the pressure relieving device setting was based on the resident's weight and if the resident's weight was stable, the setting did not need to be changed. #S-103 added that they updated the care plan with the correct setting of the pressure relieving device.

A review of resident #005’s health care record found that the resident's body weight had remained stable during 2015.

During an interview with Inspector #593 on September 25, 2015, the DOC reported that they are unsure how the setting on the pressure relieving device could be changed as they believe that the settings are supposed to be locked so that they cannot be tampered with. [s. 6. (7)]

2. The licensee has failed to ensure the care set out in the plan of care was provided to resident #006 as specified in the plan, specifically related to management of responsive behaviours.

A review of the home’s Policy: Responsive Behaviour Program dated September 16, 2013, found that PSWs shall ensure that all residents are approached for care according to their plan of care, if strategies identified on a plan of care to address responsive behaviours are ineffective this is reported to Registered Staff.

A review of resident #006’s current care plan found the resident was frequently exhibiting responsive behaviours throughout the day. The interventions to address this included:

• Allow resident #006 to listen to music.
• Family has also provided specific items to distract resident #006 or provide calm when

they are restless.
• Resident #006 enjoys sitting outside with a companion.

A review of resident #006’s current Kardex found the same interventions documented as in the resident's care plan.

Inspector #593 observed resident #006 displaying verbal responsive behaviours regularly:

September 22, 2015- resident #006 was observed to be sitting up and was being vocally responsive.

September 22, 2015- resident #006 was observed in bed at this time, however they were not asleep. They were exhibiting responsive behaviours.

September 24, 2015- resident #006 was observed to be seated in their room, they were exhibiting responsive behaviours.

September 24, 2015- resident #006 was very verbal with responsive behaviours.

September 24, 2015- resident #006 was observed seated. All other residents were at lunch. The resident was exhibiting responsive behvaiours, there were no staff in the area.

September 24, 2015- resident #006 was observed in bed at this time- they were being vocally responsive.

September 25, 2015- resident #006 was observed seated in their room. Most residents were at breakfast at this time. There were no staff in the area, the resident was being verbally responsible.

September 25, 2015- resident #006 was observed in their room. The resident was observed to be exhibiting responsive behaviours.

During observations of resident #006, Inspector #593 did not observe on any occasion, staff utilize the strategies documented in the resident's care plan for behaviour management. The resident was observed only in their room by the inspector during the inspection.

During an interview with Inspector #593 on September 24, 2015, resident #008 who was the roommate of resident #006, reported that they do not like the resident's responsive behaviours at all, resident #006 was noisy everyday and it was hard for them to watch television because of the noise. They added that they have complained to staff but nothing has changed.

During an interview with Inspector #593 on September 24, 2015, #S-100 reported that the responsive behaviours have been present for at least a year. They added that resident #006 spends most of the time in their room and their roommate resident #008 is affected by the resident's responsive behaviours.

During an interview with Inspector #593 on September 24, 2015, #S-107 reported that resident #006 has always exhibited responsive behaviours and that to manage these behaviours, they were to put music on for the resident or take them out to the front common area to sit which they liked. #S-107 further reported that it does disturb other residents, especially resident #008 who was their roommate.

During an interview with Inspector #593 on September 24, 2015, #S-102 reported that the resident was usually responsive most days and that to manage this they were supposed to put music on for the resident or take them to the lounge which also helped them settle. They added that the resident was almost always in their room as they did not always have the time to take resident #006 outside or take them for walks which they enjoy and helps to calm them. They reported that resident #008 gets upset regarding the responsive behaviours as they have communicated this to staff.

During an interview with Inspector #593 on September 25, 2015, the Activation Director reported that resident #006 likes to listen to music and staff are able to put music on for them. They added that the resident found it comforting to sit and listen to music, and that they also liked to have their items provided by family and staff should provide these for resident #006 to play with or tuck into bed with them.[s. 6. (7)]

3. The licensee has failed to ensure the care set out in the plan of care was provided to resident #001 as specified in the plan, specifically related to use of an alert device.

A review of resident #001’s health care record found a Point of Care (POC) task set up electronically which stated “Turn on alert device when resident #001 is in their room”. This intervention was also noted in the resident’s Kardex however was not documented

in the resident's care plan.

On September 24, 2015 at 1036h, Inspector #593 observed resident #001 leave their room. The alert device did not activate. They proceeded to walk down the corridor, after several minutes a PSW approached the resident and was observed to take the resident back to their room. The PSW was observed to ask #S-104 who was working nearby, "why did the alert device not activate"? #S-104 responded "because the device was switched off", #S-104 further asked " when should the device be switched on"? The PSW responded "all the time".

On September 24, 2015 at 1456h, Inspector #593 observed resident #001 watching television in their room. It was observed that the alert device was switched to the off position. Shortly after, during an interview with Inspector #593, #S-105 confirmed that the device was switched off, they reported that the alert device should have been on because the resident was in their room and they proceeded to switch the device on.

During an interview with Inspector #593 on September 23, 2015, #S-106 reported that resident #001 does have an alert device and that if the resident leaves their room, the device will activate and it will alert staff that the resident has left their room. If this happens, they are to attend to the resident and take them for a walk or sit them in the lounge.

During an interview with Inspector #593 on September 25, 2015, the DOC reported that #S-105 is a casual staff member and may not have been aware of this intervention. They further added that they believe that one of the resident's visitors may have switched the device off and they will need to educate them regarding this intervention. [s. 6. (7)]

4. The licensee has failed to ensure the care set out in the plan of care was provided to resident #005 as specified in the plan, specifically related to the provision of oral nutrition supplements.

A review of resident #005's current care plan found that the resident is at high nutritional risk and the interventions included a specific oral nutrition supplement BID (twice daily) and a second oral nutrition supplement at HS (evening) snack. A review of resident #005's physician's orders found an order for the first oral nutrition supplement twice daily at Med Pass that began six months earlier; and the second oral nutrition supplement that began over a year earlier.

A review of resident #005's MAR found that in July 2015, a '9' was documented meaning other/refer to progress notes for five dates in July under one of the oral nutrition supplements and four dates in July for the other oral nutrition supplement. In September 2015, a '9' was documented for three days in September for one of the oral nutrition supplements. Upon review of resident #005's progress notes, it was documented that on these dates, there was no stock of the ordered oral nutrition supplement available. The progress notes did not indicate an alternative oral nutrition supplement given in place of the ordered supplements.

During an interview with Inspector #593 on September 24, 2015, the Acting Nutrition Manager reported that they were unaware that they had no stock of the two oral nutrition supplements on several occasions. They further added that the process is that nursing staff are to let dietary staff know when stock is running low so that more can be ordered and this could have happened due to a miscommunication.

During an interview with Inspector #593 on September 24, 2015, the RD reported that they were unaware that they had no stock of the two oral nutrition supplements on several occasions. They added that this should not be happening, and that they do not have a back-up plan if they run short of these supplements, so the resident would not receive the supplement that was ordered. The RD reported that the Nutrition Manager is responsible for ordering the oral nutrition supplements and they are new to the home as of July 2015 and so maybe they were working through the process of ordering and stock levels.

During an interview with Inspector #593 on September 25, 2015, the DOC reported that they were unaware that they had no stock of the two oral nutrition supplements on several occasions. Nursing staff were supposed to report to dietary staff when they are running low of the oral nutrition supplements and not out completely. They further reported that there should always be a contingency stock to prevent this from happening. [s. 6. (7)]

5. The licensee has failed to ensure the care set out in the plan of care was provided to resident #003 as specified in the plan, specifically related to the administration of oral nutrition supplements.

A review of resident #003's progress notes found an entry from the RD dated September 1, 2015, documenting that "Ensure is not available at site- will change to FF (Food First) #2- oral nutrition supplement BID". A review of resident #003's health care record found

an order written by the RD for "FF#2- HEHP + oral nutrition supplement BID at Medipass", the order was signed by the physician. The order was then signed by a member of the registered nursing team five days later and a second member of the registered nursing team six days later.

A review of the electronic physician's orders found an order for resident #003 "Food First Level #2 HE/HP + BID Medipass - oral nutrition supplement twice daily". A review of resident #003's Medication Administration Record (MAR) found no order for the oral nutrition supplement which was ordered by the RD 24 days earlier and signed for by the Physician.

During an interview with Inspector #593 on September 24, 2015, the home's RD reported that one of the nutrition interventions for resident #003 was a specific oral nutrition supplement BID with Medipass. When asked as to why this was not on the MAR, the RD reported that it could have been missed and they are going to look into the matter.

During an interview with Inspector #593 on September 25, 2015, the Director of Care (DOC) confirmed that the order for the specific oral nutrition supplement was not in the MAR which indicated that the resident had not been receiving the oral nutrition supplement as ordered. The DOC further reported that once the physician had signed the order, a member of the registered nursing staff was to also sign the order and ensure that the order was added to the MAR.

A review of the home's Policy: Food First Intervention dated November 4, 2015, found that when a resident is ordered "Food First Level 2 (FF #2)" by the Registered Dietitian (RD), the RD will write an order for "FF #2- HE/HP Plus Medipass oral nutrition supplement BID". The Nursing Staff will process the order including recording it on the MAR sheets. [s. 6. (7)]

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. 8. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one Registered Nurse (RN) who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

Inspector #593 conducted a follow-up inspection with reference to 2015_331595_0004. The home was required to become compliant with the requirement to provide 24/7 on-duty RN coverage. A compliance date of June 19, 2015 was given. A review of the RN staffing schedules between June 19, 2015 and September 20, 2015 by Inspector #593 found no on-duty RN during the following time periods:

June 20, 2015- 1830h- 2230h (4 hours)

July 4, 2015- 1830h- 2230h (4 hours)

July 6, 2015- 0630h-1430h (8 hours)

July 7, 2015- 1830h- 2230h (4 hours)

July 10, 2015- 0630h- 1430h (8 hours)

July 18, 2015- 1830h- 2230h (4 hours)

August 6, 2015- 1430h- 1630h, 1830h- 2230h (6 hours)

August 23, 2015- 0630h- 1830h (12 hours)

September 2, 2015- 0630h- 1030h (4 hours)

September 7, 2015- 0630h- 1830h (12 hours)

There was no on-duty RN during the following time periods, however there was a Manager also an RN in the home assisting with some RN duties:

July 10, 2015- 1430h-1830h (4 hours)

July 15, 2015- 0630h- 1430h (8 hours)

August 5, 2015- 0630h- 1430h (8 hours)

August 7, 2015- 0630h- 1430h (8 hours)

August 13, 2015- 0630h- 1430h (8 hours)

August 16, 2015- 1430h- 2230h (8 hours)

August 18, 2015- 0630h- 1430h (8 hours)

August 24, 2015- 0630h- 1830h (12 hours)

August 27, 2015- 0630h- 1830h (12 hours)

August 28, 2015- 0630h- 1830h (12 hours)

September 1, 2015- 0630h- 1830h (12 hours)

September 2, 2015- 1030h- 1430h (4 hours)

September 8, 2015- 0630h- 1430h (8 hours)

September 10, 2015- 0630h- 1430h (8 hours)

September 11, 2015- 0630h- 1430h (8 hours)

September 15, 2015- 0630h- 1430h (8 hours)

September 16, 2015- 0630h- 1430h (8 hours)

During an interview with Inspector #593 on September 22, 2015, the DOC reported that they or other management in the home who are also RNs will be in the building when they are unable to staff an on-duty RN. They added that they will provide assistance with the medication pass and/or doctor's visit and be a support in the building however they are still working in the capacity of their management positions.

During an interview with Inspector #593 on September 23, 2015, the DOC reported that the RN schedule is posted four weeks in advance and that there are usually vacancies on the schedule which will be filled with agency staff or management who are also RNs. Regarding filling the vacant shifts, the DOC reported that it is management first and then they will utilize agency RNs. The DOC reported that their interpretation of the regulations regarding RN staffing is that there just needs to be an RN in the building and believed that their other management staff also interpreted the regulation this way. [s. 8. (3)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #005 exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of resident #005's current care plan found that the resident had altered skin integrity to two areas.

A review of resident #005's progress notes found that there was no skin progress note for the altered skin integrity to one of the areas completed by a member of the registered nursing staff for the following time periods:

July, 2015: 12 days between wound progress notes
August, 2015: 12 days between wound progress notes
September, 2015: 16 days between wound progress notes

A review of resident #005's progress notes found that there was no skin progress note for altered skin integrity to the other area completed by a member of the registered nursing staff for the following time periods:

July, 2015: 17 days between wound progress notes
August, 2015: 19 days between wound progress notes
September, 2015: 16 days between wound progress notes

During an interview with Inspector #593 on September 24, 2015, #S-100 confirmed that resident #005 had altered skin integrity to two areas. They further reported that one of the areas was re-occurring and difficult to heal and therefore the resident used a specialized pressure relieving device.

During an interview with Inspector #593 on September 24, 2015, the DOC reported that resident #005 had altered skin integrity for since 2014, it had been a long process for this altered skin integrity to heal and it was finally getting better.

During a second interview with Inspector #593 on September 24, 2015, the DOC reported that for all new altered skin integrity, a "Wound Assessment Treatment Tool" is completed electronically, after this more regular documentation should be done minimum weekly in the progress notes for all residents with altered skin integrity. The DOC added

that there may be some instances when the skin care was completed but the weekly progress note was missed. The DOC also confirmed that the weekly progress notes were not being completed during these periods as listed above for resident #005 and that both areas of altered skin integrity were still present and required weekly assessment.

A review of the home's Policy: Skin and Wound Care Program dated September 16, 2013, found that registered nursing staff will ensure that a resident with potential for altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds; has completed a wound progress note, weekly, if altered skin integrity is a wound. This will reflect the weekly assessment of the resident related to wound status.

Non-compliance had been previously identified under inspection 2015_331595_0004, including a compliance order served May 7, 2015, pursuant to O. Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that (a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff, (i) within 24 hours of the resident's admission, (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, (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with 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 a required policy, Nutrition Care and Hydration Programs was complied with.

A review of the home's Policy: Food First Intervention dated November 4, 2015, found that when a resident is ordered "Food First Level 2 (FF #2)" by the Registered Dietitian (RD), the RD will write an order for "FF #2- HE/HP Plus Medipass BID". The nursing staff will process the order including recording it on the MAR sheets.

A review of resident #003's progress notes found an entry from the RD documenting that "Ensure is not available at site- will change to FF #2- Medipass- 60ml BID". A review of resident #003's health care record found an order, written by the RD for "FF#2- HEHP + 60ml Supplement BID at Medipass", the order was signed by the physician. The order was signed by a member of the registered nursing team five days later and a second member of the registered nursing team six days later.

A review of the electronic physician's orders found an order for resident #003 "Food First Level #2 HE/HP + BID Medipass -60ML twice daily". A review of resident #003's Medication Administration Record (MAR) September 24, 2015, found no order for the supplement, which was ordered by the RD 24 days earlier and signed for by the Physician. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that a required policy, Skin and Wound Care Program was complied with.

A review of the home's Policy: Skin and Wound Care Program dated September 16, 2013 found that Registered Nursing Staff will ensure that a resident with potential for

altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds; has completed a wound progress note, weekly, if altered skin integrity is a wound. This will reflect the weekly assessment of the resident related to wound status.

A review of resident #005's health care record found that the resident had altered skin integrity to two areas.

A review of resident #005's progress notes found that there was no progress note for the altered skin integrity to one area completed by a member of the registered nursing staff for the following time periods:

July, 2015: 12 days between wound progress notes
August, 2015: 12 days between wound progress notes
September, 2015: 16 days between wound progress notes

A review of resident #005's progress notes found that there was no progress note for the altered skin integrity to the second area completed by a member of the registered nursing staff for the following time periods:

July, 2015: 17 days between wound progress notes
August, 2015: 19 days between wound progress notes
September, 2015: 16 days between wound progress notes

During an interview with Inspector #593 on September 24, 2015, the DOC reported that for all new altered skin integrity, a "Wound Assessment Treatment Tool" was completed electronically, after this more regular documentation should be done minimum weekly in the progress notes for all residents with altered skin integrity. The DOC added that there may be some instances when the skin care was completed but the weekly note was missed. The DOC also confirmed that the weekly progress notes were not being completed during these periods as listed above for resident #005 and that both areas of altered skin integrity were still present and required weekly assessment. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 27th day of November, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GILLIAN CHAMBERLIN (593)
Inspection No. / No de l'inspection :	2015_380593_0024
Log No. / Registre no:	011811-15, 012461-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 23, 2015
Licensee / Titulaire de permis :	584482 ONTARIO INC 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	MANITOULIN LODGE 3 MAIN STREET, P. O. BOX 648, GORE BAY, ON, P0P-1H0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lee Turley

To 584482 ONTARIO INC, 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) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is required to prepare, submit and implement a plan for achieving compliance under s. 6. (7) of the LTCHA:

The plan must include, but is not limited to:

* A process to ensure that all residents requiring oral nutrition supplements, are provided the supplement that is ordered and that there is a documented record of the resident receiving the supplement.
* A process to ensure that the required oral nutrition supplements are always available in the home, including communication of stock inventory of the supplements to the Nutrition Manager.
* A process to ensure that staff are aware of their responsibilities in administering oral nutrition supplements, whether it is part of the Medication Pass, during meals or as part of the between meal nourishments.
* A process to ensure that resident #006 is provided the behavioural management interventions as per the care plan as required.
* A process to ensure that all staff are kept aware of all residents care needs if and when they change, to ensure that the care is provided as per the current assessed needs of the resident ensuring quality of care and quality of life.

This plan may be submitted in writing to Long-Term Care Homes Inspector Gillian Chamberlin at 347 Preston St, Suite 420, Ottawa, Ontario, K1S 3J4. Alternatively, the plan may be emailed to the inspector at gillian.chamberlin@ontario.ca. This plan must be received by November 6, 2015 and fully implemented by November 23, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure the care set out in the plan of care was provided to resident #003 as specified in the plan, specifically related to the administration of oral nutrition supplements.

A review of resident #003's progress notes found an entry from the RD dated September 1, 2015, documenting that "Ensure is not available at site- will change to FF (Food First) #2- oral nutrition supplement BID". A review of resident #003's health care record found an order written by the RD for "FF#2- HEHP + oral nutrition supplement BID at Medipass", the order was signed by the physician. The order was then signed by a member of the registered nursing team five days later and a second member of the registered nursing team six days later.

A review of the electronic physician's orders found an order for resident #003 "Food First Level #2 HE/HP + BID Medipass - oral nutrition supplement twice daily". A review of resident #003's Medication Administration Record (MAR) found no order for the oral nutrition supplement which was ordered by the RD 24 days earlier and signed for by the Physician.

During an interview with Inspector #593 on September 24, 2015, the home's RD reported that one of the nutrition interventions for resident #003 was a specific oral nutrition supplement BID with Medipass. When asked as to why this was not on the MAR, the RD reported that it could have been missed and they are going to look into the matter.

During an interview with Inspector #593 on September 25, 2015, the Director of Care (DOC) confirmed that the order for the specific oral nutrition supplement was not in the MAR which indicated that the resident had not been receiving the oral nutrition supplement as ordered. The DOC further reported that once the physician had signed the order, a member of the registered nursing staff was to also sign the order and ensure that the order was added to the MAR.

A review of the home's Policy: Food First Intervention dated November 4, 2015, found that when a resident is ordered "Food First Level 2 (FF #2)" by the Registered Dietitian (RD), the RD will write an order for "FF #2- HE/HP Plus Medipass oral nutrition supplement BID". The Nursing Staff will process the order including recording it on the MAR sheets. (593)

2. The licensee has failed to ensure the care set out in the plan of care was

provided to resident #005 as specified in the plan, specifically related to the provision of oral nutrition supplements.

A review of resident #005's current care plan found that the resident is at high nutritional risk and the interventions included a specific oral nutrition supplement BID (twice daily) and a second oral nutrition supplement at HS (evening) snack. A review of resident #005's physician's orders found an order for the first oral nutrition supplement twice daily at Med Pass that began six months earlier; and the second oral nutrition supplement that began over a year earlier.

A review of resident #005's MAR found that in July 2015, a '9' was documented meaning other/refer to progress notes for five dates in July under one of the oral nutrition supplements and four dates in July for the other oral nutrition supplement. In September 2015, a '9' was documented for three days in September for one of the oral nutrition supplements. Upon review of resident #005's progress notes, it was documented that on these dates, there was no stock of the ordered oral nutrition supplement available. The progress notes did not indicate an alternative oral nutrition supplement given in place of the ordered supplements.

During an interview with Inspector #593 on September 24, 2015, the Acting Nutrition Manager reported that they were unaware that they had no stock of the two oral nutrition supplements on several occasions. They further added that the process is that nursing staff are to let dietary staff know when stock is running low so that more can be ordered and this could have happened due to a miscommunication.

During an interview with Inspector #593 on September 24, 2015, the RD reported that they were unaware that they had no stock of the two oral nutrition supplements on several occasions. They added that this should not be happening, and that they do not have a back-up plan if they run short of these supplements, so the resident would not receive the supplement that was ordered. The RD reported that the Nutrition Manager is responsible for ordering the oral nutrition supplements and they are new to the home as of July 2015 and so maybe they were working through the process of ordering and stock levels.

During an interview with Inspector #593 on September 25, 2015, the DOC reported that they were unaware that they had no stock of the two oral nutrition supplements on several occasions. Nursing staff were supposed to report to

dietary staff when they are running low of the oral nutrition supplements and not out completely. They further reported that there should always be a contingency stock to prevent this from happening. (593)

3. The licensee has failed to ensure the care set out in the plan of care was provided to resident #001 as specified in the plan, specifically related to use of an alert device.

A review of resident #001's health care record found a Point of Care (POC) task set up electronically which stated "Turn on alert device when resident #001 is in their room". This intervention was also noted in the resident's Kardex however was not documented in the resident's care plan.

On September 24, 2015 at 1036h, Inspector #593 observed resident #001 leave their room. The alert device did not activate. They proceeded to walk down the corridor, after several minutes a PSW approached the resident and was observed to take the resident back to their room. The PSW was observed to ask #S-104 who was working nearby, "why did the alert device not activate"? #S-104 responded "because the device was switched off", #S-104 further asked " when should the device be switched on"? The PSW responded "all the time".

On September 24, 2015 at 1456h, Inspector #593 observed resident #001 watching television in their room. It was observed that the alert device was switched to the off position. Shortly after, during an interview with Inspector #593, #S-105 confirmed that the device was switched off, they reported that the alert device should have been on because the resident was in their room and they proceeded to switch the device on.

During an interview with Inspector #593 on September 23, 2015, #S-106 reported that resident #001 does have an alert device and that if the resident leaves their room, the device will activate and it will alert staff that the resident has left their room. If this happens, they are to attend to the resident and take them for a walk or sit them in the lounge.

During an interview with Inspector #593 on September 25, 2015, the DOC reported that #S-105 is a casual staff member and may not have been aware of this intervention. They further added that they believe that one of the resident's visitors may have switched the device off and they will need to educate them regarding this intervention. (593)

4. The licensee has failed to ensure the care set out in the plan of care was provided to resident #006 as specified in the plan, specifically related to management of responsive behaviours.

A review of the home's Policy: Responsive Behaviour Program dated September 16, 2013, found that PSWs shall ensure that all residents are approached for care according to their plan of care, if strategies identified on a plan of care to address responsive behaviours are ineffective this is reported to Registered Staff.

A review of resident #006's current care plan found the resident was frequently exhibiting responsive behaviours throughout the day. The interventions to address this included:

• Allow resident #006 to listen to music.
• Family has also provided specific items to distract resident #006 or provide calm when they are restless.
• Resident #006 enjoys sitting outside with a companion.

A review of resident #006's current Kardex found the same interventions documented as in the resident's care plan.

Inspector #593 observed resident #006 displaying verbal responsive behaviours regularly:

September 22, 2015- resident #006 was observed to be sitting up and was being vocally responsive.

September 22, 2015- resident #006 was observed in bed at this time, however they were not asleep. They were exhibiting responsive behaviours.

September 24, 2015- resident #006 was observed to be seated in their room, they were exhibiting responsive behaviours.

September 24, 2015- resident #006 was very verbal with responsive behaviours.

September 24, 2015- resident #006 was observed seated. All other residents were at lunch. The resident was exhibiting responsive behvaiours, there were no

staff in the area.

September 24, 2015- resident #006 was observed in bed at this time- they were being vocally responsive.

September 25, 2015- resident #006 was observed seated in their room. Most residents were at breakfast at this time. There were no staff in the area, the resident was being verbally responsible.

September 25, 2015- resident #006 was observed in their room. The resident was observed to be exhibiting responsive behaviours.

During observations of resident #006, Inspector #593 did not observe on any occasion, staff utilize the strategies documented in the resident's care plan for behaviour management. The resident was observed only in their room by the inspector during the inspection.

During an interview with Inspector #593 on September 24, 2015, resident #008 who was the roommate of resident #006, reported that they do not like the resident's responsive behaviours at all, resident #006 was noisy everyday and it was hard for them to watch television because of the noise. They added that they have complained to staff but nothing has changed.

During an interview with Inspector #593 on September 24, 2015, #S-100 reported that the responsive behaviours have been present for at least a year. They added that resident #006 spends most of the time in their room and their roommate resident #008 is affected by the resident's responsive behaviours.

During an interview with Inspector #593 on September 24, 2015, #S-107 reported that resident #006 has always exhibited responsive behaviours and that to manage these behaviours, they were to put music on for the resident or take them out to the front common area to sit which they liked. #S-107 further reported that it does disturb other residents, especially resident #008 who was their roommate.

During an interview with Inspector #593 on September 24, 2015, #S-102 reported that the resident was usually responsive most days and that to manage this they were supposed to put music on for the resident or take them to the lounge which also helped them settle. They added that the resident was almost

always in their room as they did not always have the time to take resident #006 outside or take them for walks which they enjoy and helps to calm them. They reported that resident #008 gets upset regarding the responsive behaviours as they have communicated this to staff.

During an interview with Inspector #593 on September 25, 2015, the Activation Director reported that resident #006 likes to listen to music and staff are able to put music on for them. They added that the resident found it comforting to sit and listen to music, and that they also liked to have their items provided by family and staff should provide these for resident #006 to play with or tuck into bed with them. (593)

5. The licensee has failed to ensure the care set out in the plan of care was provided to resident #005 as specified in the plan, specifically related to the use of a pressure relieving device.

On seven occasions during the inspection, Inspector #593 observed resident #005 in bed with a pressure relieving device set at setting number A.

A review of resident #005's current care plan found that the resident had altered skin integrity in two areas caused by prolonged pressure and one of the interventions to manage this was a pressure relieving device set at setting number B.

A review of resident #005's current Kardex found an intervention documented as "ensure pressure relieving device setting is at number B".

During an interview with Inspector #593 on September 24, 2015, #S-101 reported that the resident does use a pressure relieving device because of their altered skin integrity. They confirmed that there was a specific setting for the pressure relieving device and this would be in the resident's care plan. #S-101 further reported that restorative care have assessed the resident and they determined the setting required for the pressure relieving device.

During an interview with Inspector #593 on September 24, 2015, #S-102 reported that the resident used a pressure relieving device. They added that the setting of this device was based on the resident's weight, they were unsure exactly what the setting was however they would never need to adjust this setting.

During an interview with Inspector #593 on September 25, 2015, #S-101 reported that resident #005 used a pressure relieving device which is part of their skin care. They further reported that there was a particular setting that the device was to be set at, however they were unsure exactly what this was. #S-101 added that the setting is based on the resident's weight and their weight had been stable so the setting would not need to change.

During an interview with Inspector #593 on September 24, 2015, #S-103 confirmed that they completed the pressure relieving device assessment for resident #005. They reported that the purpose of the device was that it relieved pressure from the areas where the resident had altered skin integrity. The pressure relieving device was supposed to help with preventing and healing of altered skin integrity. #S-103 further reported that the pressure relieving device setting was based on the resident's weight and if the resident's weight was stable, the setting did not need to be changed. #S-103 added that they updated the care plan with the correct setting of the pressure relieving device.

A review of resident #005's health care record found that the resident's body weight had remained stable during 2015.

During an interview with Inspector #593 on September 25, 2015, the DOC reported that they are unsure how the setting on the pressure relieving device could be changed as they believe that the settings are supposed to be locked so that they cannot be tampered with. (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 23, 2015

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_331595_0004, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is required to prepare, submit and implement a plan for achieving compliance under s.8 (3) of the LTCHA. This plan is to include:

• Detailed steps to ensure that at least one Registered Nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.
• The home's contingency plan for ensuring 24/7 registered nursing coverage in the home should a regular registered nursing staff member be unavailable for their regular shift.
• Should the home require, the home's plan to incorporate the Director of Care (DOC) into the regular nursing team, ensuring that if and when the DOC is the Registered Nurse on-duty, they are not working in the capacity of DOC and their regular DOC hours as required in the regulations (O. Reg. 79/10, s. 213 (1)) are not impacted as a result.

This plan may be submitted in writing to Long-Term Care Homes Inspector Gillian Chamberlin at 347 Preston St, Suite 420, Ottawa, Ontario, K1S 3J4. Alternatively, the plan may be emailed to the inspector at gillian.chamberlin@ontario.ca. This plan must be received by November 6, 2015 and fully implemented by November 23, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that at least one Registered Nurse (RN) who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

Inspector #593 conducted a follow-up inspection with reference to 2015_331595_0004. The home was required to become compliant with the requirement to provide 24/7 on-duty RN coverage. A compliance date of June 19, 2015 was given. A review of the RN staffing schedules between June 19, 2015 and September 20, 2015 by Inspector #593 found no on-duty RN during the following time periods:

June 20, 2015- 1830h- 2230h (4 hours)

July 4, 2015- 1830h- 2230h (4 hours)

July 6, 2015- 0630h-1430h (8 hours)

July 7, 2015- 1830h- 2230h (4 hours)

July 10, 2015- 0630h- 1430h (8 hours)

July 18, 2015- 1830h- 2230h (4 hours)

August 6, 2015- 1430h- 1630h, 1830h- 2230h (6 hours)

August 23, 2015- 0630h- 1830h (12 hours)

September 2, 2015- 0630h- 1030h (4 hours)

September 7, 2015- 0630h- 1830h (12 hours)

There was no on-duty RN during the following time periods, however there was a Manager also an RN in the home assisting with some RN duties:

July 10, 2015- 1430h-1830h (4 hours)

July 15, 2015- 0630h- 1430h (8 hours)

August 5, 2015- 0630h- 1430h (8 hours)

August 7, 2015- 0630h- 1430h (8 hours)

August 13, 2015- 0630h- 1430h (8 hours)

August 16, 2015- 1430h- 2230h (8 hours)

August 18, 2015- 0630h- 1430h (8 hours)

August 24, 2015- 0630h- 1830h (12 hours)

August 27, 2015- 0630h- 1830h (12 hours)

August 28, 2015- 0630h- 1830h (12 hours)

September 1, 2015- 0630h- 1830h (12 hours)

September 2, 2015- 1030h- 1430h (4 hours)

September 8, 2015- 0630h- 1430h (8 hours)

September 10, 2015- 0630h- 1430h (8 hours)

September 11, 2015- 0630h- 1430h (8 hours)

September 15, 2015- 0630h- 1430h (8 hours)

September 16, 2015- 0630h- 1430h (8 hours)

During an interview with Inspector #593 on September 22, 2015, the DOC reported that they or other management in the home who are also RNs will be in the building when they are unable to staff an on-duty RN. They added that they will provide assistance with the medication pass and/or doctor's visit and be a support in the building however they are still working in the capacity of their management positions.

During an interview with Inspector #593 on September 23, 2015, the DOC reported that the RN schedule is posted four weeks in advance and that there are usually vacancies on the schedule which will be filled with agency staff or

management who are also RNs. Regarding filling the vacant shifts, the DOC reported that it is management first and then they will utilize agency RNs. The DOC reported that their interpretation of the regulations regarding RN staffing is that there just needs to be an RN in the building and believed that their other management staff also interpreted the regulation this way.

The decision to re-issue this compliance order was based on the scope which has the potential to affect all residents in the home, the severity indicates a potential for actual harm and the compliance history which despite previous non-compliance (NC) issued including a compliance order, NC continues with this area of the legislation. (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 23, 2015

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2015_331595_0004, CO #006;

Pursuant to / Aux termes de :

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

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

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

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

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

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

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

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

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

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

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

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

Order / Ordre :

The licensee is hereby ordered to ensure that residents exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds, receive 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 and that, when clinically indicated, these residents' wounds are reassessed at least weekly by a member of the registered staff and that these assessments are documented correctly and consistently.

Furthermore, the licensee is hereby ordered to comply with Policy: Skin and Wound Care Program dated September 16, 2013. Registered Nursing Staff will ensure that a resident with potential for altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds; has completed a wound progress note, weekly, if altered skin integrity is a wound. This will reflect the weekly assessment of the resident related to wound status.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #005 exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of resident #005's current care plan found that the resident had altered skin integrity to two areas.

A review of resident #005's progress notes found that there was no skin progress note for the altered skin integrity to one of the areas completed by a member of the registered nursing staff for the following time periods:

July, 2015: 12 days between wound progress notes
August, 2015: 12 days between wound progress notes
September, 2015: 16 days between wound progress notes

A review of resident #005's progress notes found that there was no skin progress note for altered skin integrity to the other area completed by a member of the registered nursing staff for the following time periods:

July, 2015: 17 days between wound progress notes
August, 2015: 19 days between wound progress notes
September, 2015: 16 days between wound progress notes

During an interview with Inspector #593 on September 24, 2015, #S-100 confirmed that resident #005 had altered skin integrity to two areas. They further reported that one of the areas was re-occurring and difficult to heal and therefore the resident used a specialized pressure relieving device.

During an interview with Inspector #593 on September 24, 2015, the DOC reported that resident #005 had altered skin integrity for since 2014, it had been a long process for this altered skin integrity to heal and it was finally getting better.

During a second interview with Inspector #593 on September 24, 2015, the DOC reported that for all new altered skin integrity, a "Wound Assessment Treatment Tool" is completed electronically, after this more regular documentation should be done minimum weekly in the progress notes for all residents with altered skin integrity. The DOC added that there may be some instances when the skin care was completed but the weekly progress note was missed. The DOC also confirmed that the weekly progress notes were not being completed during these periods as listed above for resident #005 and that both areas of altered skin integrity were still present and required weekly assessment.

A review of the home's Policy: Skin and Wound Care Program dated September 16, 2013, found that registered nursing staff will ensure that a resident with potential for altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds; has completed a wound progress note, weekly, if altered skin integrity is a wound. This will reflect the weekly assessment of the resident related to wound status.

Non-compliance had been previously identified under inspection 2015_331595_0004, including a compliance order served May 7, 2015, pursuant to O. Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that (a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff, (i) within 24 hours of the resident's admission, (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, (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The decision to re-issue this compliance order was based on the scope which although only affecting one resident, the severity indicates a potential for actual harm and the compliance history which despite previous non-compliance (NC) issued including a compliance order, NC continues with this area of the legislation. (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 23, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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 23rd day of October, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gillian Chamberlin

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