Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 5, 2018	2018_678680_0005	002415-18	Resident Quality Inspection

Licensee/Titulaire de permis

Maplewood Nursing Home Limited
73 Bidwell Street TILLSONBURG ON N4G 3T8

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

Maple Manor Nursing Home
73 Bidwell Street TILLSONBURG ON N4G 3T8

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

TRACY RICHARDSON (680), HELENE DESABRAIS (615), NATALIE MORONEY (610)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 20, 21, 22, 23 and 26, 2018.

The following complaint was inspected concurrently with the Resident Quality Inspection:
Log #003169-18, IL-55481-LO regarding an alleged elopement of a resident from the home.
The following Critical Incidents were inspected concurrently with the Resident Quality Inspection:
Log #028591-17, Critical Incident System Report # 1049-000013-17, regarding a fall which resulted in injury.
Log #021673-17, Critical Incident System Report #1049-000010-17, regarding a fall which resulted in injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the RAI Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, a member of Residents' Council, Family Council President, family members and residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care, and the general maintenance and cleanliness of the home. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed medication administration and drug storage areas, resident and staff interactions, infection prevention and control practices, the posting of Ministry of Health and Long-Term Care information and inspection reports.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Reporting and Complaints
Residents' Council
Safe and Secure Home

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

- **6 WN(s)**
- **4 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following interdisciplinary programs were developed and implemented in the home: 3. A continence care and bowel management program to promote continence and to ensure that residents were clean, dry and comfortable.

During the Resident Quality Inspection (RQI) a specified resident was identified as having a change in continence. The resident was admitted to the home on a certain date, and on admission minimum data set (MDS), the documentation showed that the resident was continent for both bowel and bladder. On another date, the MDS documentation showed that the resident was continent of bowel and usually continent of bladder. And on another date, the MDS documentation showed that the resident was frequently incontinent of urine.

Review of the policy titled "Continence Care and Bowel Management Program," dated April 19, 2017, stated:
"Collaborate with resident/substitute decision maker (SDM) and family and interdisciplinary team to conduct a bowel and bladder continence assessment utilizing a clinically appropriate instrument (Appendix A: Bladder and Bowel Continence Assessment).
-on admission
-quarterly
-after any change in condition that may affect bladder or bowel function

The assessment must include identification of casual factors (e.g. recurrent urinary tract infections), patterns (e.g. daytime/night time urinary incontinence, constipation), type of incontinence (e.g. urinary-stress, urge, overflow or functional), medications (e.g. diuretics) and potential to restore function (e.g. prompted voiding, bedside commode, incontinent product) and identify type and frequency of physical assistance necessary to facilitate toileting."

Review of the resident's MDS assessments showed no evidence to support that a continence assessment had been completed with changes in continence level. During review of the MDS assessment, it showed no documentation related to the type of incontinence and potential to restore function.

In an interview a registered staff member stated that there was no formal resident continence assessment completed on admission, the information was taken on admission from families and the resident, and then put into their plan of care.

In an interview with the RAI coordinator they stated that the continence program was going to be initiated this year.

In an interview the Director of Care (DOC) shared that the home did not have a formal continence assessment on admission. That the MDS was completed with changes in the resident's condition. The DOC stated that a continence assessment previously was done in the home but when they reverted back to paper assessments the continence assessment did not continue. The DOC stated that it's been at least two years since they have used the continence assessment mentioned in the policy. The DOC stated that the plan was to initiate the continence team this year, and that at present there was no team lead for this program. The DOC shared that they did not meet to review continence in a committee meeting.

The DOC acknowledged that the type of incontinence was not mentioned in the MDS assessment. The DOC stated that the instrument mentioned as Appendix A: Bladder and Bowel continence assessment form was not being utilized within the facility as mentioned in the policy. The DOC acknowledged that there was no formal assessment completed with the changes in bladder continence for the resident, and parts of the continence program had not been initiated.

The licensee has failed to ensure that the following interdisciplinary programs are developed and implemented in the home: 3. A continence care and bowel management

program to promote continence and to ensure that residents are clean, dry and comfortable. [s. 48. (1) 3.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

On a specific date, as part of the Resident Quality Inspection (RQI), an Inspector completed a tour of the first floor home area and found three fire doors unlocked with no staff present, and one door in the basement dining area unlocked with no staff present. The Inspector was able to open the door to non-residential areas without entering a code and no alarm sounded.

Maplewood Nursing Home policy titled "Safe Environment," dated April 19, 2017, stated in part that the magnetic door lock would be on at all times unless the area was supervised by staff and that the code to bi-pass the alarm was" a specific code.

Personal Support Worker (PSW) was interviewed and stated the fire doors should be locked, and would require a pass-code to open the door to exit and that the only time the doors would be unlocked would be in an emergency. The PSW observed the first floor south door to be unlocked with the inspector.

The Director of Care (DOC) said that all the fire doors should be locked at all times, and was also unaware as to why the doors were not locked.

The Administrator acknowledged that staff were able to use a key to activate the locks on the fire exit doors, and the Administrator was not aware that the doors had been deactivated. On a specific date, the Inspector asked the Administrator if staff were able to bi-pass the codes for the doors using a different code. The Administrator acknowledged they could, and further explained that on a specific date, the hydro flipped off. Administrator stated that they had forgotten to reset the doors until another specified later date.

The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff. [s. 9. (1) 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 all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimetres.

Observations during the Resident Quality Inspection showed that on the first floor one window on the north and one window on the south resident lobby areas were opened greater than 15 centimetres.

The DOC acknowledged that the windows were opened more than 15 centimetres during an audit on a specific date, and that the tab safety systems to prevent the windows from rising greater than 15 centimeters were not in place.

The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimetres. [s. 16.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every window in the home that opens to the outdoors cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who was incontinent received an assessment that: included identification of casual factors, patterns, types of incontinence and potential to restore function with specific interventions and was conducted using a clinically appropriate assessment instrument that was designed for assessment of incontinence where the condition or circumstance required.

During the Resident Quality Inspection (RQI) a specified resident was identified as having a change in continence. The resident was admitted to the home on a specific date, and on admission minimum data set (MDS), the documentation showed that the resident was continent for both bowel and bladder. On another date the MDS documentation showed that the resident was continent of bowel and usually continent of bladder. And at a later date, the MDS documentation showed that the resident was frequently incontinent of urine.

Review of the home's policy titled "Continence Care and Bowel Management Program," dated April 19, 2017, stated:
"Collaborate with resident/substitute decision maker (SDM) and family and interdisciplinary team to conduct a bowel and bladder continence assessment utilizing a clinically appropriate instrument (Appendix A: Bladder and Bowel Continence Assessment).
-on admission
-quarterly
-after any change in condition that may affect bladder or bowel function
The assessment must include identification of casual factors (e.g. recurrent urinary tract infections), patterns (e.g. daytime/night time urinary incontinence, constipation), type of incontinence (e.g. urinary-stress, urge, overflow or functional), medications (e.g. diuretics) and potential to restore function (e.g. prompted voiding, bedside commode, incontinent product) and identify type and frequency of physical assistance necessary to facilitate toileting."

Review of the resident's MDS assessments showed no evidence to support that an assessment had been completed until a specific date. During review of the MDS assessment it showed no documentation related to the type of incontinence and potential to restore function.

In an interview a Personal Support Worker (PSW) stated that the resident previously was able to toilet on their own, but they had now declined cognitively and required assistance.

The PSW shared that the resident was continent until the resident had several incidents and then there was a decline in their cognitive abilities. The PSW stated that the resident was able to ask for assistance in toileting.

In an interview a registered staff member stated that there was no formal assessment completed on admission, the information was taken on admission from families and the resident, and then put into their plan of care.

In an interview the Director of Care (DOC) shared that the home did not have a formal assessment on admission. That the MDS was completed with changes in the resident's condition. The DOC stated that a continence assessment previously was done in the home but when they reverted back to paper assessments the continence assessment did not continue.

In an interview the DOC stated that the plan was to initiate the continence team this year, and that at present there was no team lead for this program. The DOC shared that they did not meet to review continence in a committee meeting. The DOC acknowledged that there was no formal assessment completed with the changes in bladder continence for the resident.

The licensee has failed to ensure that a resident who was incontinent received an assessment that: included identification of casual factors, patterns, types of incontinence and potential to restore function with specific interventions and was conducted using a clinically appropriate assessment instrument that was designed for assessment of incontinence where the condition or circumstance required. [s. 51. (2) (a)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 1. A resident who was missing for less than three hours and who returned to the home with no injury or adverse change in condition.

A complaint was submitted to the MOHLTC, related to the elopement of a specific resident.

A Critical Incident System report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), during the complaint inspection, related to the elopement of a the resident.

A review of the resident's progress notes, stated in part:Critical elopement listing a time, and a visitor came to staff to say that resident was outside the building. DOC had been notified of the incident.

During an interview, a registered staff member stated that on the specific date, they arrived at the home and that the nurse working that day told them that the resident was found outside the home. The registered staff member said that when an elopement occurs, they would need to notify the DOC and concurred that the DOC was notified that day and this was documented in the resident’s progress notes.

During an interview, the Administrator and the DOC stated that the resident was found on the ground outside the home, that it was an elopement and were aware of that incident. The Administrator and the DOC said that it was not reported within one business day to the Director, and that the expectation would be that when a resident eloped, that it should be reported to the Director.

The CIS was submitted to the MOHLTC the day of the complaint inspection.

The licensee has failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 1. A resident who was missing for less than three hours and who returned to the home with no injury or adverse change in condition. [s. 107. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Critical Incident System report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), regarding a specific resident who sustained fall with injury.

The CIS report stated that the resident stated that they had fallen while using a specific assistive device.

Review of the home's policy titled "Falls Prevention and Management Program," dated March 7, 2011, stated: "When a resident has fallen, the resident will be assessed regarding the nature of the fall and associated consequences, the cause of the fall and

the post fall care management needs."
"Registered Nursing Staff: 9. Redo the Fall Risk Assessment and complete a Post Fall Screen for Resident/Environmental Factors (Appendix D) form, review the fall prevention interventions and modify the plan of care in collaboration with the interdisciplinary team."

In an interview the resident shared that they were using their assistive device and that when they stood up, they fell and injured a specific area of their body.

Review of the resident's chart showed that the resident had a fall, and that the resident complained of pain to specific areas of their body. The resident was sent to the hospital for assessment. The resident returned to the home with treatment for a specific injury.

Review of the resident's chart showed that there was no falls assessment form completed for the fall.

In an interview the Director of Care (DOC) stated that there was no evidence to support that a post fall assessment was completed after this fall and the expectation was that there would have been one done. The DOC stated that they had seen trends where this was not being done and the staff were educated to complete them even when a resident goes to the hospital.

The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

Issued on this 6th day of March, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TRACY RICHARDSON (680), HELENE DESABRAIS (615), NATALIE MORONEY (610)
Inspection No. / No de l'inspection :	2018_678680_0005
Log No. / No de registre :	002415-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 5, 2018
Licensee / Titulaire de permis :	Maplewood Nursing Home Limited 73 Bidwell Street, TILLSONBURG, ON, N4G-3T8
LTC Home / Foyer de SLD :	Maple Manor Nursing Home 73 Bidwell Street, TILLSONBURG, ON, N4G-3T8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marlene Van Ham

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.
O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 48 (1) 3.

Specifically the licensee must:
a) Fully implement a continence care and bowel management program.
b) Train all required staff on the program. Attendance records are to be maintained related to this training.
b) Ensure resident #022 and any other resident, has a continence assessment completed with any change in their continence status.

Grounds / Motifs :

1. The licensee has failed to ensure that the following interdisciplinary programs were developed and implemented in the home: 3. A continence care and bowel management program to promote continence and to ensure that residents were clean, dry and comfortable.

During the Resident Quality Inspection (RQI) a specified resident was identified as having a change in continence. The resident was admitted to the home on a

certain date, and on admission minimum data set (MDS), the documentation showed that the resident was continent for both bowel and bladder. On another date, the MDS documentation showed that the resident was continent of bowel and usually continent of bladder. And on another date, the MDS documentation showed that the resident was frequently incontinent of urine.

Review of the policy titled "Continence Care and Bowel Management Program," dated April 19, 2017, stated:
"Collaborate with resident/substitute decision maker (SDM) and family and interdisciplinary team to conduct a bowel and bladder continence assessment utilizing a clinically appropriate instrument (Appendix A: Bladder and Bowel Continence Assessment).
-on admission
-quarterly
-after any change in condition that may affect bladder or bowel function
The assessment must include identification of casual factors (e.g. recurrent urinary tract infections), patterns (e.g. daytime/night time urinary incontinence, constipation), type of incontinence (e.g. urinary-stress, urge, overflow or functional), medications (e.g. diuretics) and potential to restore function (e.g. prompted voiding, bedside commode, incontinent product) and identify type and frequency of physical assistance necessary to facilitate toileting."

Review of the resident's MDS assessments showed no evidence to support that a continence assessment had been completed with changes in continence level. During review of the MDS assessment, it showed no documentation related to the type of incontinence and potential to restore function.

In an interview a registered staff member stated that there was no formal resident continence assessment completed on admission, the information was taken on admission from families and the resident, and then put into their plan of care.

In an interview with the RAI coordinator they stated that the continence program was going to be initiated this year.

In an interview the Director of Care (DOC) shared that the home did not have a formal continence assessment on admission. That the MDS was completed with changes in the resident's condition. The DOC stated that a continence assessment previously was done in the home but when they reverted back to

paper assessments the continence assessment did not continue. The DOC stated that it's been at least two years since they have used the continence assessment mentioned in the policy. The DOC stated that the plan was to initiate the continence team this year, and that at present there was no team lead for this program. The DOC shared that they did not meet to review continence in a committee meeting.

The DOC acknowledged that the type of incontinence was not mentioned in the MDS assessment. The DOC stated that the instrument mentioned as Appendix A: Bladder and Bowel continence assessment form was not being utilized within the facility as mentioned in the policy. The DOC acknowledged that there was no formal assessment completed with the changes in bladder continence for the resident, and parts of the continence program had not been initiated.

The licensee has failed to ensure that the following interdisciplinary programs are developed and implemented in the home: 3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.

The severity of this issue was determined to be a level 2 as minimal harm or potential for actual harm for residents. The scope of the issue was a level 3 as it was widespread. The home had a level 2 compliance history as there was 1 or more unrelated non-compliance in the last 3 years. (680)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 02, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 5th day of March, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Tracy Richardson

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