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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 14, May 21, 2014	2014_191107_0009	H-000379-14	Resident Quality Inspection

Licensee/Titulaire de permis

NIAGARA HEALTH SYSTEM
63 THIRD STREET, WELLAND HOSPITAL SITE, WELLAND, ON, L3B-4W6

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

NIAGARA HEALTH SYSTEM, WELLAND HOSPITAL SITE, EXTENDED CARE UNIT
155 Ontario Street, St. Catharines, ON, L2R-5K3

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

MICHELLE WARRENER (107), BARBARA NAYKALYK-HUNT (146), ROBIN MACKIE (511), THERESA MCMILLAN (526)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 8, 9, 10, 11, 14, 15, 16, 22, 23, 24, 2014

During the course of the inspection, the inspector(s) spoke with Residents, residents' family members/friends, the Administrator, Director of Care (DOC), Registered Nursing staff, including Registered Nurse (RN), Registered Practical Nurse(RPN), Personal Support Workers (PSWs), Registered Dietitian (RD), Food Services Supervisor (FSS), Dietary Aides, Recreation Manager, Recreation Aides, Environmental Supervisor, Environmental Aide, and Laundry and Housekeeping Supervisors and Aides

During the course of the inspection, the inspector(s) Toured the home, observed resident care, meal and snack service, laundry maintenance and housekeeping practices, reviewed clinical health records of residents, reviewed relevant policies and procedures

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 90(2)(a)]
The licensee did not ensure that procedures were developed and implemented to ensure that electrical and non-electrical equipment, specifically mechanical tub lifts and tubs were kept in good repair and maintained at a level that met manufacturer specifications.
A) Two non-electrical/non-mechanical tubs with accompanying mechanical tub lifts were available for use in the home on April 14, 2014. According to the Administrator and Personal Support Workers, the tubs in the North West and North East wings, and the accompanying lifts, were original to the home. A copy of the manufacturer's specifications for the tubs and tub lifts were not available for review in the home.
B) In the North West tub room, and in the IC0108 tub room, safety straps on the seat of the lift were frayed and in poor repair.
C) The North East tub lift had a small one inch by two inch piece of paper taped to the lift stating, "Do not lift chair past red ball". The red ball was suspended from the ceiling. A Personal Support Worker interviewed was unaware of the reason for the signage and red ball and proceeded to raise the lift to the red ball. The chair immediately ceased in the raised position and was unable to be lowered. A call to maintenance was placed by the RPN on duty at 1305 hours and a maintenance worker arrived to fix the lift. During interview, the maintenance worker did not believe the lift had been inspected and the red ball was a corrective measure for the malfunctioning of the lift. The maintenance worker stated the red ball/signage had been in place for approximately 10 years.
D) The Environmental Services Supervisor was not aware that the tub lifts and tubs had not been inspected routinely as part of the home preventive maintenance

program.
E) No records were available to confirm the lifts had been inspected for safe resident use and the Administrator and Environmental Manager confirmed that the lifts were not being inspected.
F) The home did not have any procedures in place to address how the tubs and tub lifts would be maintained, repaired, inspected and by whom and how often. Personal support workers who were interviewed had not been directed to inspect the belts for condition on a daily basis.
G) Two Personal Support Workers confirmed that residents were routinely bathed in the tub in both wings using the bath chairs.
H) A non-electrical/non mechanical tub in the North West tub room was in disrepair. The surface of the rim of the tub's left side (facing the head of the tub) and the bottom of the tub near the drain was not smooth and was not easy to clean. Staff confirmed that the tub was used daily. [s. 90. (2) (a)]

2. [O.Reg. 79/10, s. 90(2)(d)]
The licensee did not ensure that procedures were developed and implemented to ensure that all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.
A)On April 11, 2014 the South West and North West shower room tubs were observed to have the finish coming off of the bottom, near the drain, and top left side of tub. There were water stains on the ceiling tiles of the South West room and there was extensive staining of the shower room floors. On the bottom corners of the South West, North West and North East shower hard surface baseboards, there was moderate damage to the corners where the baseboard corners were cracked and corroded metal strips were exposed. Interview with the Environmental Manager/Hospitality on April 15, 2014 confirmed disrepair of the baseboard, tubs and shower floors was unacceptable by the home's standard and that the home did not ensure that procedures were developed and implemented to ensure that all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks. [s. 90. (2) (d)]

Additional Required Actions:

CO # - 901 was served on the licensee. 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. 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. [O.Reg. 79/10, s. 8(1)(a)]
The home's policies and procedures for the nutrition and food service departments were not consistently in compliance with and implemented in accordance with all applicable requirements under the Act.
A) The home's "Dietary Referral and Communication Form" for referral to the Registered Dietitian identified pressure ulcer stage III, IV, II(not healing) was to be referred to the Registered Dietitian for assessment. Requirements under regulation s. 50(2)(b)(iii) require all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds to be assessed by a Registered Dietitian who is a member of the staff of the home. The home's referral form was not consistent with the requirements set out in the regulations.
B) The home's "Nutrition Care and Hydration Programs" policy identified the Roles and Responsibilities of the Nutrition Manager as following up on residents who were unstable or had skin breakdown, to observe residents who had been identified with swallowing and chewing difficulties, and make referrals to speech language pathology as required. Regulations 26(4) and 50(2)(b)(iii) require the Registered Dietitian to complete an assessment when there is a significant change in the resident, to assess nutrition and hydration status and risks, and to assess changes to skin integrity.
C) The home's policy "Texture Modified Diets" stated, "If the Dietitian will not be in the facility for a number of days the RN or RPN is to consult with the Food service Supervisor (FSS). If the FSS deems a diet texture change may be necessary, the diet change can be processed provided a referral is made for the RD to assess the resident during the next site visit." The policy also stated, "A nutritional assessment was not required for a diet texture change if: Altered texture diet is offered as a trial to determine if a diet texture change is necessary; the family or resident requests an altered textured diet; or if altered texture meat is substituted for the regular entree

during meal service at the request of the resident or discretion of the RPN if the entree cannot be managed by the resident."
The home's policy did not differentiate the differences in diet texture upgrades versus downgrades and the inherent risks involved in upgrading the resident's diet without a nutritional assessment by the Registered Dietitian. Regulation 26(3)13,14,19 require that the plan of care be based on at a minimum, an interdisciplinary assessment of nutritional status, including any risks related to nutrition care and hydration, and safety risks and regulation 26(4) requires that a Registered Dietitian completes a nutritional assessment for all residents whenever there is a significant change in a resident's health condition and assessed the nutrition and hydration status and risks.
D) The home's Nutritional Intervention Program identified the implementation of nutritional interventions for prevention of weight loss, poor intake, poor skin integrity, however, the policy did not include the need for a nutritional assessment and involvement of the resident/substitute decision maker in the implementation of the program. Legislative requirement s. 6(5) requires the resident or substitute decision maker to be involved in the development and implementation of their plan of care (the policy is a standard intervention for all residents - not individualized). Legislative requirement s. 6(2) requires the plan of care to be based on an assessment of the resident and the needs and preferences of that resident, and Regulation 50(2)(b)(iii) requires an assessment by the Registered Dietitian related to interventions for skin integrity concerns and Regulation 26(3)13,14 require the resident's plan of care to be based on an assessment of nutritional status, including height, weight and any risks relating to nutrition care. [s. 8. (1) (a)]

2. [O.Reg. 79/10, s. 8(1)(b)]
The licensee did not ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy, or system, was complied with.
A) The home's Nutrition Care and Hydration Programs policy stated that the nursing department and Food Services Supervisor were to refer residents with identified nutritional and hydration issues to the Dietitian for further assessment. Residents were not consistently referred to the Dietitian when their nutrition goals were not met or when their status changed. Both dietary and nursing staff confirmed that the Dietitian referral system was not consistently used for the communication of nutritional concerns to the Registered Dietitian. (107)
B) The home's Med Pass Program stated the Registered Dietitian would determine the particular resident's energy/protein needs and prepare a plan of care. The

Registered Dietitian did not determine each resident's current energy, protein, or fluid needs in relation to the Med Pass orders for resident #137. (107)
C)The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with specifically related to the home's Skin and Wound Management policy #S-10 which was revised on January 2014.
i) The policy stated that "Bath nurses complete head to toe skin inspections and document (weekly) reporting findings accurately to the RN/RPN for follow up". Staff indicated that skin assessments were located either in the bath binder or the resident's health record. Weekly skin assessments were not completed/documented between over a 49 day period for resident #117. Skin Inspection tools (Bath day) for resident #129 were not found for a 36 day period. Staff confirmed that skin assessments were not documented if the bath sheet was not completed. (526)
ii) The policy stated that the RN and RPN "Reviews bath day skin care assessment tool and provides direction to the PSW/HCAs". Skin Inspection tools (Bath day) for resident #117 did not contain registered staff signatures for tools completed by PSW/HCA's on five occasions over a two month period. Registered staff confirmed that they did not consistently review the bath sheets as per the policy. (526)
iii) The policy stated that the RN and RPN "initiates referrals and consults with members of the interdisciplinary team". Staff confirmed that Resident #117's progress notes indicated the resident had open areas on their skin. The registered staff and Registered Dietitian confirmed that referrals to the Registered Dietitian were not made consistently and confirmed that resident #117 had not been referred to the Registered Dietitian as the result of the skin integrity issue identified over a one month period. (526)
Resident #129 progress notes indicated that altered skin integrity was observed over a two month period. The Registered Dietitian confirmed that she did not receive a referral regarding resident #129. (526)
iv) The policy stated that the RN and RPN "implements a plan of care in accordance with the skin protocols of the home". Resident #117 presented with altered skin integrity over a two month period. No nursing entry in the resident's care plan following the identification of these skin integrity issues was found. Staff confirmed that nursing specific care plan for resident #117 could not be found. (526) [s. 8. (1) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance 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 is in compliance with and is implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

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

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)]
The licensee did not ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to residents.
A) The written care plan for resident #155 provided specific direction for staff related to a mobility device, however, a note posted at the back of the resident's bed provided different direction. The PSW's giving care to the resident stated they followed the one posted at the bedside. The directions to staff related to the resident's mobility device were unclear. (146)
B) On April 11, 2014 resident #126 was observed to have a medical device in place. Direction provided to staff related to the medical device was not consistent or clear

between the resident's MDS Kardex in hard copy, the most recent care plan, printed April 23, 2014, Physician's order and Treatment Administration record (TAR) printed April 11, 2014. Interview with the registered staff on April 11, 2014 confirmed the written plan of care did not provide clear direction to staff and others who provided direct care to the resident. (511)
C) Resident #121's care plan directed staff to do mouth care twice daily. The resident's kardex directed staff to do mouth care daily. This information was confirmed by staff and the health record. (146)
D) Resident #131's care plan directed staff to do mouth care after meals and at bedtime, which would be four times per day. The resident's kardex directed staff to do mouth care daily. (146)
E) The plan of care for resident #129 did not provide clear directions in relation to oral hygiene. The plan for oral hygiene identified that the resident required assistance with oral hygiene, however, did not identify the required frequency for staff to assist with oral hygiene, did not identify that the resident wore dentures, and did not identify that the resident did not have their own teeth. Staff interviewed were unable to tell inspector by reviewing the plan of care if the resident had teeth in addition to dentures or dentures only and confirmed that the plan of care should have included clearer direction related to the resident's oral hygiene needs.(107) [s. 6. (1) (c)]

2. [LTCHA, 2007, S.O. 2007, c.8, s. 6(4)(a)]
The licensee did not ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #117's skin integrity so that their assessments were integrated, consistent with and complemented each other.
A) Resident #117's RAI-MDS assessment indicated "NONE" in the past 7 days to the Section M2 statement: "Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue"; and "NO" to the Section M3 statement: "Resident has had a pressure ulcer that was resolved or cured in LAST 90 DAYS".
The resident's progress notes indicated that the resident had open areas on their skin. There was no indication in the progress notes if these wounds had healed or not. Staff who conducted the RAI-MDS assessment did not collaborate with and were not consistent with staff who noted the pressure ulcers in the progress notes. (526)
B) Registered staff wrote a progress note about resident #117 stating concerns with skin integrity. During the same time frame, non registered staff completed the skin assessment tool on bath day for resident #117 and indicated that the resident's skin was clear. Staff did not collaborate with one another to ensure that their skin assessments were consistent and complemented one another. (526)

C)Discrepancies were noted in the documentation relation to resident #139's skin integrity. The skin inspection tool (bath day) observation records reflected problems with skin integrity over a three month period. Documentation by different staff in the progress notes identified problems with skin integrity and did not identify that the area had healed, however, the nutritional quarterly review during the same time period did not identify skin concerns. Staff did not collaborate with each other in the assessment of the resident's skin and staff stated they were not always clear on the status of the resident's skin integrity. (107) [s. 6. (4) (a)]

3. [LTCHA, 2007, S.O. 2007, c.8, s.6(7)]
The licensee did not ensure that the care set out in the plan of care for residents was provided to the residents as specified in their plans.
A) Care set out in the plan of care was not provided to resident #117 as specified in the plan according to resident #117's care plan, discussions with registered and non registered staff, and observations of the resident by the inspector. The resident's care plan was based on the RAI-MDS assessment and indicated that the resident was to have two one half rails up at all times when in bed for safety; staff confirmed inspector observations that two full rails were in the up position while resident was in bed. (526)
B) The care set out in the plan of care was not provided to resident #115 as specified in their plan. Resident #115's plan of care directed staff not to provide a specific device with the resident's fluids, due to a health condition. At the morning snack pass on April 22, 2014 the resident received the device with their beverage. At 1450 hours the resident had two beverages containing the device at their bedside. During interview, the resident stated that they did not ask for the devices and staff routinely put the device in their beverages when they were provided to the resident. Staff confirmed that the resident was not to receive the devices with their beverages. (107)
C) The care set out in the plan of care was not provided to resident #129 as specified in relation to recreation programming. The resident's plan of care had a goal for at least one specific program per week. During interview, a Recreation Aide stated that the resident was not currently on a specific program, however, another staff member confirmed the resident required the specific programming. The attendance records reflected that the programming was offered to the resident twice over one month, however, no specific programming was recorded for the two subsequent months. Documentation did not reflect that the specific programs were discontinued. The Recreation Manager confirmed that if the specific programs were offered to the resident and refused, the information was still required to be recorded on the participation records. The specific programming was not offered to the resident as specified in the resident's plan of care. (107) [s. 6. (7)]

4. [LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(b)]
The licensee did not ensure that resident #117 was reassessed and the plan of care reviewed and revised when their care needs changed.
A) Resident #117's progress notes indicated that the resident care needs changed in relation to skin integrity. The plan of care was not revised at these times.
B) Resident #117's wound/treatment progress note indicated that the resident had developed skin integrity concerns. No further notations in the progress notes or care plan were found to guide care provision regarding the plan of care for wounds, particularly regarding specific treatments the resident was receiving. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with section 6(4)(a) staff and others involved in the different aspects of care of residents collaborate with each other in the assessment of the residents so that their assessments are integrated and are consistent with and complement each other; 6(7) the care set out in the plan of care is provided to residents as specified in their plan; and 6(10)(b)residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the residents' care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #4: 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. [LTCHA, 2007, S.O. 2007, c.8, s. 8(3)]
The licensee did not ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times.
A) A review of staffing schedules from March 24 to April 20, 2014 was conducted and indicated that at least one RN, excluding the Director of Care (DOC), was not present during at least ten shifts in this time period including the following: evening shifts on March 25, 28, 30, April 1, 5, and 6, 2014; and night shifts on April 7, 8, 12, and 13, 2014. The staffing clerk and Administrator confirmed that an RN was not on duty and present in the home during the identified shifts between March 24 and April 20, 2014. [s. 8. (3)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 15(1)(a)]
Where bed rails were used, not all bed systems were evaluated in accordance with evidence-based practices to minimize risk to residents.
A) The home commissioned a person to complete a bed entrapment zone audit of all the resident bed systems in 2012. The results of the audit did not identify if any of the home's beds failed one or more zones of entrapment which could potentially cause injury to the resident and did not include a record for all of the beds in the home. Only a small percentage of beds had data available. The monitoring tool that the home kept on record for each bed did not identify any of the zone entrapment hazard potential. (107)
B) During a tour of the home, some gaps between the bed rails and mattresses were observed. These areas were not those identified as part of the audit or were on beds that were changed after the audit without a re-assessment of the safety zones. The home had a mix of bed models and mattresses of different ages. Some beds were furnished with quarter length assist bed rails and others with older full length rails. A number of bed frames had missing mattress keepers or they were not in place to keep the mattresses from sliding side to side. When beds without mattress keepers were tested, the mattresses easily slid off the frame of the bed. (107)
C) The Administrator confirmed the home did not have a process in place to identify which mattresses had been changed or replaced since the audit in 2012 and that new beds were received in 2013. The new beds did not receive a post entrapment zone assessment to determine if the new beds and mattresses were compliant with entrapment zone safety. (107)
D) Documentation in the progress notes for resident #139 stated that the resident got stuck between their mattress and bed rails. There was no evidence to support that the resident's mattress had been assessed for safety prior to or after the incident. (107)
E) Resident #126 was interviewed and confirmed the staff put two bed rails up on their bed when they went to sleep at night. Resident #126's bed rails were observed to be full bed rails. Review of the clinical records and interview with the DOC confirmed the home did not assess the resident and evaluate their bed system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. (511) [s. 15. (1) (a)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 68(2)(c)]
The nutrition care and hydration programs did not include the implementation of interventions to mitigate and manage the identified risks related to nutrition care and dietary services and hydration.
A) A system was not in place under the food services and hydration program to ensure that residents requiring diet texture or fluid consistency changes received an assessment, including risk management strategies for trial diets. The current system did not include an assessment of risk, abilities, causal factors, feeding/swallowing strategies, etc. prior to the implementation of a trial diet texture and did not differentiate between diet texture upgrades and downgrades. Three of three residents (#131, #119, #126) reviewed with diet texture changes did not have an assessment prior to the implementation of the texture upgrade. [s. 68. (2) (c)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

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

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 73(1)1]
The daily and weekly menus for residents receiving an altered texture meal were not communicated to residents and their families. The regular texture daily and weekly menus were posted, however, the modified texture menu varied significantly from the regular textured menu, and the modified texture menus were not communicated.
A) At the lunch meal April 8, 2014 a family member had asked the staff serving the meal what was available for the modified texture. Staff were not sure what the item was (stated it was not labelled for staff) and the menu was not posted for residents and their families.
B) At the lunch meal April 11, 2014, the modified texture menu was also not posted and varied significantly from the regular menu (regular menu was hamburger and turkey sandwich, texture modified menu offered beef bourginoun or chicken).
C) At the lunch meal April 22, 2014 the posted menu stated pancakes with bacon. The demonstration plates did not contain bacon and residents were not informed that the choice came with bacon. The modified textures were given roast pork instead of bacon, however, this was not communicated to residents. Resident #119 was told that it was bacon when being assisted by staff. The demonstration plate contained a

corned beef sandwich on rye bread, however, residents requiring a minced menu were provided minced roast beef sandwiches on whole wheat bread. The posted menu did not identify the difference in the menu and the difference between the demonstration plate and the planned menu was not communicated to residents. [s. 73. (1) 1.]

2. [O.Reg. 79/10, s. 73(1)7]
Not all residents were provided sufficient time to eat at their own pace.
A) Several residents voiced concerns with rushed breakfast meal service during the stage 1 RQI interview process.
B) Resident #155 voiced concerns that they were rushed and not offered a full meal (as per the planned menu) on certain days. Resident's Food Committee meeting minutes of October 17, 2013 reflected residents concerns about feeling rushed when residents were brought late to the dining room and that trays should be provided once the 0845 hour cut off time was exceeded.
B) Resident #139 voiced concerns over being rushed with their breakfast meal when they were taken to the dining room late. The resident's progress notes also reflected the resident was concerned they were being rushed to eat if they go to the dining room late for the breakfast meal.
C) Resident #124 voiced concerns about residents being rushed in the dining room at the breakfast meal. [s. 73. (1) 7.]

3. [O.Reg. 79/10, s. 73(1)9]
Not all residents were provided with eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible at the lunch meal April 8, 2014.
A) Resident #141 required cueing, encouragement, or total assistance with eating if needed. The resident was not assisted with their meal and was struggling to eat independently. The resident's assistive device was positioned incorrectly and did not allow the resident to use the adaptive aid to assist with eating. The resident was observed pushing the food off the plate and unable to get the food on the spoon. The resident was left in the dining room at the end of the meal and was not assisted until 1320 hours (the lunch meal began at 1200 hours). The resident ate when being fed by staff.
B) Resident #142 required cueing and encouragement at meals and assistance from staff when unable to feed themselves. The resident sat sleeping in-front of their soup from 1210 hours to 1218 hours when verbal prompting was provided. The resident was served their entree at 1227 hours, however, sat without eating until 1251 hours

when their entree was cleared (virtually untouched) and dessert was placed on the table and the resident sat in-front of their dessert until 1309 hours when the dessert was cleared and not consumed. Staff did not physically assist the resident with eating and the resident was not feeding themselves.
C) Resident #135 did not receive the required level of assistance with eating their soup. The soup was placed in-front of the resident who sat without assistance being provided. The resident then attempted to grab the mug of soup, however, tipped the cup over and spilled the soup on the table. The soup was cleared away, however, a replacement for the soup was not provided. The resident was assisted by staff with their entree when an additional staff member arrived at the table.
D) Resident #133 required cueing and encouragement and total assistance with eating. The resident sat not eating at 1311 hours. The resident took one spoonful of dessert, however, did not continue eating. The resident was not assisted with their dessert and did not eat it.
E) Assistive devices were not available on the afternoon snack cart April 16, 2014. Resident #156 required a sippy cup at meals and snacks. Staff interviewed stated assistive devices are not routinely placed on the snack cart and staff are required to go get them as needed from the servery. [s. 73. (1) 9.]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 129(1)(a)(ii)]
The licensee did not ensure that drugs were stored in an area or a medication cart that was secure and locked.
A) On April 23, 2014 at 1600 hours, a medication cart was observed in the hallway unattended and with drawers unlocked and one slightly ajar. A resident was sitting in a wheelchair in the hallway four metres away. The monitor and the electronic MAR were also open and in full view with resident name, room number and medication names in full view. The medication nurse was in a resident room and not within view of the unsecured medication cart or the resident sitting nearby. The DOC was alerted, locked the cart, closed the electronic screen and confirmed that this was an unacceptable practice. (146)
B) On April 8, 9, 10, 11 and 14, 2014 topical medications were observed on the top of the treatment cart in the nursing station of a specific wing and not secured and locked; registered staff and DOC confirmed that the medications should have been in a locked location. (146)
C) On April 8, 2014 at 1530 hours inspectors observed an unlocked medication cart in the hallway and not within view of the RPN staff. (146)
D) April 14, 2014, during a medication pass observation RPN staff were observed to leave the medication cart unlocked in hallway while they administered medications in the dining room between 1230 and 1250 hours. Drugs were not stored in an area or medication cart that was consistently secure or locked. (526)
C) On April 24, 2014 at 1600 hours, the inspectors observed an unlocked unattended medication cart outside a room. Staff was providing care to a resident in the room and did not have a visual sight-line to the cart. The registered staff member returned to the cart and said they had thought that they had locked the cart and were aware that the cart should have been locked. (107) [s. 129. (1) (a) (ii)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #9: 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,
(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;
O. Reg. 79/10, s. 50 (2).

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. [O.Reg. 79/10, s. 50(2)(a)]
The licensee did not ensure that, (a) a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, (ii) upon any return of the resident from hospital.
A) Resident #124 was hospitalized and returned to the home the next day. Three registered staff who were interviewed stated that the home's expectation was that the head to toe assessment tool used for admission was also to be used for re-admission. The re-admission skin assessment was not completed on resident #124 when re-admitted from hospital. This information was confirmed by health record review and by registered staff. [s. 50. (2) (a)]

2. [O.Reg. 79/10, s. 50(2)(b)(i)]
The licensee did not ensure that a resident exhibiting altered skin integrity, including skin breakdown, ulcers, skin tears or wounds received a skin assessment by a

member of the registered nursing staff using a clinically appropriate assessment instrument.
A) The licensee did not ensure that resident #119 who exhibited a wound received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. Registered staff confirmed that they did not assess the wound using a clinically appropriate assessment tool. There was no evidence of the skin assessment in progress notes where staff had indicated that the wound note would have been found.
B)Registered staff confirmed that the home's accepted clinically appropriate assessment in a "Wound/treatment progress note" included "Location and brief description of the area being treated; size/stage/depth, discharge (include amount and description); progress (indicate status, improvement or worsening); evidence of infection /action taken, indicate referral, eg. Physician, dietitian, physiotherapist". Staff confirmed that all skin and wound assessments were located in the progress notes.
C) Resident #129 exhibited an alteration in skin integrity, however, skin and wound incidents were not assessed.(526)
D)Resident #137 had altered skin integrity noted in the progress notes. Registered nursing staff confirmed that the skin assessment tool that the home used to document skin and wound assessments was a progress note specifically for skin and wound assessments. An assessment, using the home's progress note form, was not completed for the areas. Staff confirmed that the areas were not assessed by a member of the registered nursing staff and was not documented in the home's progress notes. (107)
E) The Skin inspection tool (bath day) records for resident #139 identified concerns with skin integrity. Registered staff interviewed stated that the skin assessments were to be recorded in the progress notes on the specific template for wounds. Documentation in the progress notes did not reflect an assessment of the open area by a member of the registered nursing staff using the specified progress note. (107)
[s. 50. (2) (b) (i)]

3. [O.Reg. 79/10, s. 50(2)(b)(iii)]
The licensee did not ensure that a resident who exhibited altered skin integrity including skin breakdown, pressure ulcers, skin tears and wounds had been assessed by a Registered Dietitian who was a member of the staff of the home.
A) Resident #117's progress notes indicated the resident had altered skin integrity. Progress notes, dietary assessment forms, registered staff and the Registered Dietitian confirmed that a Registered Dietitian did not assess the resident on these two

occasions when alteration in skin integrity was noted. (526)
B)Resident #139, who was exhibiting altered skin integrity, was not assessed by a Registered Dietitian and changes were not made to the plan of care related to nutrition and hydration.
i) Documentation in the resident's progress notes identified concerns with skin integrity. The resident was seen by the Dietitian for the quarterly review, however, the review did not include an assessment of the resident's skin or a re-assessment of the resident's nutritional requirements related to the skin impairment or significant weight loss. The Dietitian confirmed that she was not aware of the resident's skin integrity issues.
ii) The skin observation sheets completed by Personal Support Workers (PSWs) identified concerns with skin integrity. The resident was not assessed by the Dietitian in relation to the resident's poor skin integrity with an assessment of the resident's nutritional requirements in relation to the identified areas of skin breakdown. (107)
C) Resident #129 was noted to have an alteration of skin integrity. No Registered Dietitian progress notes or assessments were found regarding the areas. The home's Registered Dietitian confirmed that resident #129 did not receive a dietary assessment in response to skin integrity concerns. (526)
D) Resident #137 was not assessed by the Registered Dietitian in relation to impaired skin integrity. The Dietitian ordered a nutritional supplement, however, an assessment in related to skin impairment was not completed/documented. (107) [s. 50. (2) (b) (iii)]

4. [O.Reg. 79/10, s. 50(2)(b)(iv)]
The licensee did not ensure that a resident who exhibited altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered staff.
A) Registered staff confirmed that skin care assessments were documented in the progress notes using the Point-click-care online documentation. The progress notes for resident #117 identified skin integrity concerns. The progress notes did not contain evidence of weekly skin assessments following the identification of the poor skin integrity over a three month period. A registered staff confirmed that resident #117's altered skin integrity was not reassessed by a registered nursing staff at least weekly following the initial assessments of the skin areas. (526)
B) Resident #137, exhibiting altered skin integrity, was not reassessed at least weekly by a member of the registered nursing staff for multiple areas of concern on the resident's skin. One area was not re-assessed by a member of the registered nursing staff until it was noted there was a significant worsening of the area. Staff confirmed

that the area was not reassessed at least weekly by a member of the registered nursing staff and that weekly assessment of the area was indicated. Other areas of skin integrity concerns were noted, however, there was no re-assessment of the areas by a member of the registered nursing staff. Staff confirmed that weekly re-assessment by the registered nursing staff was not completed for these areas. (107)
C) Resident #139 was not reassessed at least weekly by a member of the registered staff in relation to skin integrity concerns. Registered staff interviewed stated skin assessments were to be completed in the progress notes under the specific progress note for wounds. Skin assessments were not completed weekly by the registered staff in relation to the open area. (107) [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 3(1)1]
The licensee did not ensure that the following rights of residents were fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
A) The care plan for resident #155 directed staff to provide disciplinary interventions for certain behaviours. Two caregivers interviewed stated that the intervention was followed but not very often; they estimated that maybe once every two months. The resident stated they did not like the intervention and felt like a prisoner when staff did it. The DOC confirmed that the practice was unacceptable.
B) The care plan for resident #155 directed staff to take items away from the resident for certain behaviours. The resident stated the intervention was initiated once for a 24 hour period about a year ago but not since. The resident was upset with the intervention. [s. 3. (1) 1.]

2. [LTCHA, 2007, S.O. 2007, c.8, s. 3(1)4]
The licensee did not ensure that the following rights of residents were fully respected and promoted: 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
A) Resident #133 was interviewed just prior to the lunch meal. The Inspector observed that the resident's clothing was soiled with large spots of dried residue.
B) Resident #131 was observed sitting with soiled clothing on. The Inspector observed the soiled clothing; face was unshaven; fingernails on both hands were long with black dirt underneath; seatbelt was soiled and padding between legs was soiled. The next day, the resident was again observed to be wearing soiled clothing and the seatbelt and padding between their legs was soiled. [s. 3. (1) 4.]

3. [LTCHA, 2007, S.O. 2007, c.8, s. 3(1)8]
The licensee did not ensure that the following rights of residents were fully respected and promoted: 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
A) Registered staff was observed administering treatments to residents while eating lunch in the dining room with other residents eating their lunch close by. One of the residents voiced concerns with privacy while the treatment was being provided. [s. 3. (1) 8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with sections 3(1)1 Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity; 3(1)4 Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs; and 3(1)8 Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 17(1)]
The licensee did not ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by the resident at all times.
A) Resident #115 was observed to have a bedside call bell that was only 6 inches in length and tucked up behind the bedside curtain. During interview the resident indicated they were unable to access the call bell and had to yell to get the staff's attention when assistance was required. The resident further stated that contacting the staff in this manner was difficult. Resident #115's clinical records indicated the call bell was to be available and accessible. Interview with the DOC confirmed an alternative resident-staff communication and response system was not implemented. (511)
B)On April 8 and 9, 2014, the inspector observed that in an identified room, the bathroom call bell beside the toilet was wrapped around the grab bar, thereby preventing the bell from being activated from the toilet seat. (146) [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 26(4)]

The licensee did not ensure that a Registered Dietitian who was a member of the staff of the home, completed a nutritional assessment for all residents on admission and whenever there was a significant change in a resident's health condition and assessed the matters referred to in paragraphs 13 and 14 of subsection (3).
A) The home's Registered Dietitian did not complete a nutritional assessment for resident #139 when there was a significant change in the resident's weight and hydration status.
i) Resident #139 had a significant weight loss of 10.7% over 6 months, however, the resident's nutritional requirements were not re-assessed in relation to the significant weight loss. The resident also had documented concerns with skin integrity.
ii) The resident had a decrease in hydration over three quarterly reviews. The Dietitian confirmed they did not assess the decrease in hydration and the resident's target hydration goal was not based on an individualized assessment of the resident's requirements. The target identified on the resident's plan of care had not been revised since 2010. The resident was noted to have a urinary tract infection, concentrated urine and fluid status changes.
iii) During interview, the resident stated they were unable to obtain fluids overnight when they were thirsty.
iv) A referral to the Registered Dietitian for re-assessment was not completed.
B)The home's Registered Dietitian did not complete a nutritional assessment for resident #119 when there was a significant change in the resident's health condition and did not assess the resident's nutritional status, including risks related to nutrition and hydration status.
i) Documentation in the progress notes reflected the Food Service Supervisor requested a diet texture upgrade and an order was written by the physician for the diet texture change. An assessment was not completed by the Dietitian in relation to the diet texture change, nor was it assessed by the Dietitian at the next quarterly review.
ii) During interview the resident stated they were having difficulty chewing the current diet due to having no teeth and stated the previous diet was easier to manage.
iii) The resident was consistently consuming less fluid than their fluid goal, however, the resident was not assessed by the Dietitian in relation to the continued poor hydration.
iv) The resident had a decrease in their hydration recorded at the resident care conference. The resident was not assessed by the Dietitian in relation to the poor hydration and goals were not revised in relation to the decrease in their hydration.
C) The home's Registered Dietitian did not complete a nutritional assessment for resident #137 when there was a significant change in the resident's status related to skin integrity and hydration, and the Dietitian did not assess the resident's nutritional

status, including risks related to nutrition and hydration status.
i) Resident had ongoing issues with skin integrity, constipation and poor hydration. The Dietitian ordered a nutritional supplement, however, an assessment of the quantity, timing, nutritional requirements and intake in relation to the supplement, and an assessment of the resident's nutrition and hydration risks was not documented. The Dietitian confirmed that a formal assessment was not completed.
ii) Hydration was triggered at the quarterly review, however, the poor hydration was not assessed by the Registered Dietitian in relation to goals identified for the resident. The Dehydration/Fluid Maintenance Resident Assessment Protocol (RAP) was triggered for "insufficient fluid; did not consume all or almost all liquids provided during the last 3 days". An assessment of the poor hydration was not completed by the Dietitian and action was not taken to address the poor hydration (resident was consuming 66% of their target fluid goal).
iii) The resident was being followed by the Food Service Supervisor, however, a referral to the Registered Dietitian for re-assessment did not occur when goals for the resident were not being met.
D) The home's Registered Dietitian did not complete a nutritional assessment of resident #126 when there was a change in the resident's condition and assess the resident's nutritional status and risks related to nutrition and hydration status.
i) The resident had their diet texture upgraded without an assessment by the Dietitian related to the nutrition and hydration risks. The resident's diet was initiated by a Speech Language Pathologist in the hospital and the resident returned to the home on the diet. The resident expressed frustration with the wait for a re-assessment by the Speech Language Pathologist and the resident's diet was upgraded to regular texture and for staff to monitor for negative outcomes. An assessment related to risks, chewing and swallowing patterns/risks, etc. was not completed by the Dietitian prior to the diet texture upgrade.
ii) The Food Service Supervisor wrote a progress note indicating she was requesting a diet texture change and that she spoke with the Dietitian and the Dietitian agreed to the trial diet order. No documentation was completed by the Dietitian and the Dietitian confirmed that an assessment was not completed prior to the diet texture upgrade. [s. 26. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that a registered dietitian who is a member of the staff of the home completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition and assesses the matters referred to in paragraphs 13 and 14 of subsection (3), to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 29(1)(b)]
The licensee did not ensure that where there was a written policy to minimize the restraining of residents and to ensure that any restraining that was necessary was done in accordance with this Act and the regulations; and that this policy was complied with.
A) Resident #126 was observed to have two full bed rails. Interview with the resident confirmed that both rails were placed in the up position when the resident was in bed preventing them from getting out of bed. The resident stated they did not use the rails during the night for positioning themselves unless the staff came in and told the resident to use them when they were changing their brief. The resident stated they did not want both rails up all night long. Interview with the MDS-RAI nurse indicated the two full side rails were being used as a Personal Assistance Services Device (PASD) and that when both rails were left in the raised position all night the device had a restraining property. A review of the Restraints and PASD policy, revised in October 2013 stated, "When the device has a restraining property the procedure relating to restraints applies the use and monitoring of the PASD". Interview with the DOC confirmed the home had not ensured the Restraints and PASD policy was being complied with for resident #126 as it related to their PASD. [s. 29. (1) (b)]

Additional Required Actions:

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

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 30(2)]

The licensee did not ensure that any actions taken with respect to a resident under a program, including assessment, reassessments, interventions and the resident's responses to interventions were documented.
A) On two identified days, resident #119 was observed to have a wound on their skin. There was no evidence in the progress notes that the resident had been injured. Staff confirmed that this incident was not in the progress notes and that skin integrity issues should be documented in the progress notes. (526)
B) The licensee did not ensure that actions taken with respect to resident #137, under the dietary services and hydration program, including assessments and reassessments, were documented. Progress notes indicated the Food Service Supervisor and Registered staff were requesting a nutritional supplement be ordered related to poor intake. The Registered Dietitian was at the home and a supplement was ordered, however, an assessment for the nutritional supplement was not documented by the Dietitian. The Registered Dietitian confirmed that a nutritional assessment was not documented for the initiation of the resident's nutritional supplement. (107)
C) Actions taken with respect to resident #126, under the dietary services and hydration program, including assessments and reassessments, were not documented by the Registered Dietitian. Progress notes indicated the Food Service Supervisor requested to have the resident's diet upgraded and spoke with the Dietitian in relation to the texture upgrade. Documentation was not completed by the Dietitian to reflect the conversation or an assessment in relation to the resident's texture upgrade. (107)
D) The licensee did not ensure that actions taken with respect to food and fluid intake for residents at nutrition risk was documented under the dietary services and hydration program.
i) Resident #139, with identified risks related to nutrition and hydration, did not have consistent documentation to reflect that a snack (food) was consistently offered to the resident. There were 20/31 missing entries for the afternoon snack and 8/31 missing entries for the evening snack in one month; 25/31 missing entries for the afternoon snack and 11/31 missing entries for the evening snack the next month; 11/27 missing entries for the afternoon snack and 4 missing entries for the evening snack the subsequent month; 22/31 missing entries for the afternoon snack and 12/31 missing entries for the evening snack the next month. An evaluation of the data was not possible due to the missing information. (107)
ii) Resident #137 had incomplete documentation on the Meal Flow Sheets over a three month period. The first month reviewed there were 24/31 missing entries for the afternoon snack, 9/31 missing entries for the evening snack pass; 23/28 missing entries for the afternoon snack and 10/28 missing entries for the evening snack pass

the next month; and 22/31 missing entries for the afternoon snack pass and 7/31 missing entries for the evening snack pass the subsequent month. It was unclear if a snack was offered to the resident, was refused, or just not documented. The resident was at nutritional risk. (107)
iii) Resident #126 had incomplete documentation on the Meal Flow Sheets over a two week period. Documentation did not include the dinner meal on two dates, and the afternoon snack pass 12/13 days and the evening snack pass on three days. The resident was at nutritional risk. (107)
iv) Resident #119 had incomplete documentation on the Meal Flow Sheets for a two week period. The resident was at nutritional risk. Documentation was incomplete for two dinner meals, and missing entries were noted for 9/13 afternoon snack passes and 2/13 evening snack passes. (107) [s. 30. (2)]

Additional Required Actions:

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

WN #15: 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. [O.Reg. 79/10, s. 51(2)(a)]
The licensee did not ensure that each resident who was incontinent received an assessment that included 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 required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.
A) Resident #129 Minimum Data Set-Resident Assessment Instrument (MDS-RAI), section O indicated frequent bladder incontinence. Review of the most recent clinical records that included the resident care plan, RAPs and progress notes confirmed the resident experienced urinary incontinence but had not included assessments to determine the type of incontinence and potential to restore function with specific interventions. Interview with the DOC and Administrator confirmed the resident did not receive an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. [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 with ensuring that 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, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 57(2)]
The licensee did not respond to the Residents' Council in writing within 10 days of receiving Resident Council concerns or recommendations.
A) The Resident Council meeting minutes of February 27, 2014 indicated that residents were concerned about people opening bathroom doors when occupied. The Council suggested that a sign be put on the bathroom doors. The home did not provide a written response to the Council.
B) The November 2013 minutes indicated that residents had concerns about laundry being given to the wrong residents. The home did not provide a written response within 10 days.
C) The Resident Council chair stated they had voiced concerns to the home about the LTCH staff wearing hospital uniforms prior to the distribution of the uniforms several months ago. The resident/Council felt that the home would feel too much like an institution or a prison. The home did not provide a written response to the concern.
D) The above information was confirmed by the Resident Council chair and the Administrator. [s. 57. (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 with ensuring if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (2) The licensee shall ensure that each menu,
(a) provides for adequate nutrients, fibre and energy for the residents based on the current Dietary Reference Intakes (DRIs) established in the reports overseen by the United States National Academies and published by National Academy Press, as they may exist from time to time; and O. Reg. 79/10, s. 71 (2).

s. 71. (2) The licensee shall ensure that each menu,
(b) provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time. O. Reg. 79/10, s. 71 (2).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 71(2)(a)]
The Registered Dietitian confirmed that the home's menu was not evaluated in relation to the current Dietary Reference Intakes (DRIs). The menu provided several items that were low in total protein in the quantities provided and it was also not clear that the DRI for fibre was being routinely met. Some examples of low protein items: a 2 oz portion of bologna in bologna sandwiches; peanut butter sandwiches; pancakes served with a couple of strips of side bacon. [s. 71. (2) (a)]

2. [O.Reg. 79/10, s. 71(2)(b)]
The menu did not provide for a variety of foods each day. Numerous residents voiced concerns to inspectors about repetition of items on the current menu during this inspection and food quality was triggered for inspection during Stage 2 of the inspection.
A) Numerous menu items were repeated throughout the menu cycle, within weeks, and the same items were served on the snack menu that were served at meals. Some examples:
- Tuna salad sandwiches were served at the lunch meal week 1, afternoon snack Tuesday Week 1, Friday evening snack Week 2, Friday Week 3 lunch and Saturday week 3 evening snack
- Peaches, pears or fruit cocktail (contains peaches and pears) were served Week 1 Tuesday supper, Saturday lunch (in the cottage cheese plate and for dessert), and in the fruit cocktail Wednesday lunch, pears on Saturday supper and Sunday supper in

the fruit cocktail, Week 2 Wednesday supper, Thursday lunch, Friday lunch, Week 3 Tuesday supper, Thursday supper, Saturday lunch, Sunday supper
- two patty type items served at the supper meal on consecutive days Week 1 Wednesday supper was Salisbury steak and Thursday supper veal cutlet, then turkey cutlet Thursday supper Week 2
- apple spice loaf served Week 1 Saturday lunch and at snack Sunday evening, Sunday snack week 2, Friday afternoon snack Week 3
- cookies served (digestives, soft cookies, arrowroots, social teas, or wafers 6/7 days at snacks Weeks 1and 2 and 5/7 days Week 3, lunch Monday Week 2
- peanut butter and jam sandwiches served lunch Tuesday Week 2, Saturday evening snack Week 1, Sunday evening snack Week 2, Monday evening snack Week 3
- apple sauce Monday lunch and Saturday supper Week 2
- jello lunch Thursday Week 1, Wednesday lunch Week 2, Tuesday lunch Week 3
- Roast beef sandwich Week 1 Tuesday lunch, Week 2 Saturday lunch, Tuesday Week 3 lunch minced menu
- Swiss cheese sandwich Wednesday lunch Week 1, Thursday lunch Week 2
- bologna sandwich Tuesday lunch Week 1, Saturday lunch Week 2
- egg frittata Tuesday lunch Week 1, Wednesday supper Week 2, then omelet lunch Week 2 and supper Tuesday Week 3
- macaroni and cheese Thursday lunch Week 1 and Friday supper Week 2
- fish sticks Wednesday supper Week 1, Monday lunch Week 2
- 2 sandwich choices together for the lunch meal Monday Week 3
- Plums and 2 bite brownie in same combination lunch Monday Week 1 and Thursday Week 3
- fruit creme cookies Sunday lunch Week 2, Friday lunch Week 3
- Perogies Casserole Sunday lunch Week 1, Friday supper Week 3
- Turkey sandwich lunch Friday week 1, Saturday lunch Week 3
- Coleslaw served lunch Friday Week 1, Friday lunch Week 3
- The pureed menu is repetitious and items are repeated throughout the menu cycle.

B) The menu did not provide for all food groups in keeping with Canada's Food Guide each day. Canada's Food Guide requires three servings of meat or meat alternatives for males aged 51+, however, only two servings were offered for residents who chose the 2nd choice lunch entree Week 3 Tuesday. [s. 71. (2) (b)]

3. [O.Reg. 79/10, s. 71(4)]
Not all planned menu items were offered and available at each meal and snack.
A) Planned portion size was not followed for the lunch meal April 8, 2014. A 4 oz portion of beets was required, however, beets were portioned with tongs and only a

few were on the plate; 2 bread "pucks" were used for the pureed bread, however, the menu required a #16 or 2 oz portion; 2 "pucks" of meat were required for the pureed beef sandwich, however, only 1 "puck" was used; the menu required a #8 scoop of pureed beets, however, only 1 container of the pureed beets was sent to the floor so staff used a teaspoon to portion the beets and residents did not receive a full portion; the planned menu required a #16 (2oz) portion of pureed honeydew melon for dessert, however, only 1 portion was available for the dining room and a whole mug (8oz) was served. A choice of pureed dessert was not available for the rest of the residents in the dining room requiring a pureed menu; the therapeutic extension menu identified a 55gm portion of scrambled eggs to be served for the pureed menu, however, a #8 (4oz) portion of eggs was used - the therapeutic extension menu did not provide clear direction to staff portioning meals related to the correct portioning utensil.
B) Staff confirmed that there was not always sufficient quantity of pureed menu items available to provide choice for residents requiring a pureed menu.
C) At the observed afternoon snack pass April 16, 2014, the planned menu required soaked cookies for the minced and pureed texture diets, however, soaked cookies were not available or offered to residents. Residents requiring minced textures were offered regular cookies and a pureed snack (that followed the planned menu) was not available for residents requiring a pureed menu.
D) Pancakes soaked with syrup were required at the lunch meal April 22, 2014. A resident requiring a pureed menu related received pancakes with added coffee (not all pancakes were soaked and of an appropriate texture) for moisture.
E) Resident #155 voiced concerns that they were not offered a full meal (as per the planned menu) on certain days. The resident stated they were only offered a muffin for the breakfast meal. During interview, dietary staff confirmed that residents who were late to the dining room were not always offered a full breakfast as per the planned menu and may receive a muffin for the breakfast meal. Resident's Food Committee meeting minutes of October 17, 2013 reflected residents concerns about feeling rushed when residents are brought late to the dining room and that trays should be provided once the 0845 hour cut off time was exceeded. Resident #139 also voiced concerns over being brought late for the breakfast meal and not receiving a full meal. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with the regulations section 71(2)(a) each menu provides for adequate nutrients, fibre and energy for the residents based on the current Dietary Reference Intakes (DRIs) established in the reports overseen by the United States National Academies and published by National Academy Press, as they may exist from time to time; 71(2)(b) each menu provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time; and 71(4)the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 89(1)(a)(ii)]
The licensee did not ensure as part of the organized program of laundry services under clause 15 (1) (b) of the Act, that residents' personal items and clothing were labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing.
A) Review of the home's laundry policy, revision date October 2013, stated the laundry staff labelled the resident's personal clothing within 48 hours of admission and of acquiring new clothing. Interview with the laundry staff on April 14, 2014 indicated resident #150's labelling of clothing had not been completed within 48 hours of admission. [s. 89. (1) (a) (ii)]

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 with ensuring that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, procedures are developed and implemented to ensure that residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 229(2)(b)]
The licensee did not ensure that the interdisciplinary team that co-ordinated and implemented the infection prevention and control program met at least quarterly.
A) A review of the home's interdisciplinary team meeting minutes for 2013 and 2014 confirmed the home met twice in 2013 on April 22, 2013 and November 6, 2013 respectively. There were no minutes for 2014. Interview with the DOC confirmed the home had not ensured the interdisciplinary team that co-ordinated and implemented the program met at least quarterly. [s. 229. (2) (b)]

2. [O.Reg. 79/10, s. 229(2)(e)]
The licensee did not ensure that a written record was kept relating to the Infection Prevention and Control Program evaluation, including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.
A) A review of a document dated January 18, 2014 was provided by the Administrator on April 24, 2014 indicating the Infection Prevention and Control Policy and Procedure Manual was reviewed on January 18, 2014 by herself. Interview with the DOC and Administrator confirmed the licensee's review of the Infection Prevention and Control Policy and Procedure Manual did not include an evaluation of the program that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. [s. 229. (2) (e)]

3. [O.Reg. 79/10, s. 229(4)]
The licensee did not ensure that staff participated in the implementation of the infection control program.
A) The home's Infection Prevention and Control Program included Policy #025 which was last reviewed January 2014. Policy #025 stated that "hand hygiene must be performed before and after contact with a resident; before performing invasive procedures..." (pg. 1).
B) A registered staff was observed administering medications to residents. The staff person's personal beverages were observed on the top of the medication cart. This registered staff did not wash their hands in accordance with the home's infection control program on the following occasions: after giving a treatment to a resident (#151) and prior to administering medication to resident #152; after giving medication to resident #153 and before giving a treatment to resident #154. The staff person was touching their face and hair prior to giving medications without washing hands their

hands afterward.
C) The home's Infection Control policy and procedure #36, last reviewed January 2014, directed staff to refer to the Niagara Region Public Health "Outbreak Management Guidelines for Health Care Facilities" (2012) for outbreak management. The guidelines directed staff to use passive surveillance using a daily surveillance form for daily review by the Infection Control Person (ICP). Registered staff and DOC confirmed that any symptoms of infectious disease should be recorded in the progress notes and an informal list of residents with symptoms is maintained by registered staff. The DOC indicated that she reviewed progress notes and the informal surveillance sheets daily for any indication of infectious disease outbreaks; the DOC stated that she would be unaware of infectious cases if they were not documented in progress notes or on the surveillance sheet.
D) On April 8 and 9, 2014 resident #119 was observed to be complaining of a stuffy head and nasal congestion. On April 10, 2014 the resident was observed reporting a hoarse voice to staff. Inspection of resident #119 progress notes revealed no entries regarding respiratory congestion/infection between dates April 8 and 12, 2014. The resident's electronic Medical Record indicated that the resident received an antibiotic during this time period.
E) On April 8, 9, and 10, 2014, registered staff on the resident care area were questioned about whether there were any residents exhibiting infectious symptoms on those days; they stated that there were not and that there were no residents to enter into the informal surveillance form. Resident #119 was exhibiting respiratory infection symptoms between April 8 and 11, 2014 without these symptoms being documented in the progress notes or on an informal surveillance form. Staff did not participate in implementing the infection control program by not assessing or documenting resident #119's infectious symptoms for at least four days. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance regulations sections 229(2)(b)the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; 229(2) (e) a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented; and 229(4)the licensee shall ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 35(2)]
The licensee did not ensure that each resident of the home received fingernail care, including the cutting of fingernails.
A) On April 8, 2014 and April 9, 2014, resident #131 was observed to have long fingernails soiled with dark material under the nails.
B) On April 15, 2014, resident #155 was observed to have black debris under the fingernails of both hands during an interview at 1100 hours. The resident was showered before breakfast the same morning. Fingernails were not cleaned. [s. 35. (2)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 86. Accommodation services programs

Specifically failed to comply with the following:

s. 86. (2) Where services under any of the programs are provided by a service provider who is not an employee of the licensee, the licensee shall ensure that there is in place a written agreement with the service provider that sets out the service expectations. O. Reg. 79/10, s. 86 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 86(2)]
Where services under any of the programs were provided by a service provider who was not an employee of the licensee, the licensee did not ensure that there was in place a written agreement with the service provider that sets out the service expectations.
A) Interview with resident #139, #119 and #129 indicated all had complained of missing clothing in 2013 and 2014. Review of the Resident Council minutes for January 23, 2013 indicated concerns with missing laundry items and in March 27, 2014 indicated laundry concerns for residents were 'ongoing'. Interview with the full time laundry aide on April 14, 2014 confirmed the home had ongoing concerns with missing personal laundry and used an external service provider for linens only. She stated that when personal laundry was included in the linen supply by accident and was unlabelled, the personal laundry would not come back. The staff member confirmed if the personal laundry was labelled it may be returned by the external service provider in three weeks. The Administrator stated in an interview that personal laundry that was sent to the external service provider would be returned in 48 hours and regular linens in 24 hours. A review of the service provider agreement (named "Agreement for Supply of Reusable Operating Room Linen for Niagara Health System) provided by the Administrator did not outline service expectations for missing personal laundry and was dated October 28, 2005 and expired November 12, 2007. There was an option to extend the agreement to November 2010. The Administrator confirmed the expiration of the agreement and that the home did not ensure that there was in place a written agreement with the service provider that set out the service expectations. [s. 86. (2)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 87(2)(a)]
The licensee did not ensure as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that procedures were developed and implemented for, (a) cleaning of the home, including, (i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and (ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.
A) On April 9, 2014 the North West and IC0108 West unit tub/shower rooms were noted to have moderate amount of black soiled area within the grout lines of the bottom quarter of the tub/shower area. A review of the cleaning records confirmed the two rooms had been cleaned by the housekeeper daily from April 7-15, 2014. Interview with the Environmental Services Aid (ESA) confirmed the cleaning of the walls and grout lines were not part of the routine or deep cleaning schedule or job description and could not confirm when they were last cleaned. Interview with the Environmental Manager confirmed the walls of the tub/shower were unclean and cleaning of the grout lines and walls should be part of their routine cleaning to prevent black soil build up. [s. 87. (2) (a)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 110. (1)	CO #002	2013_105130_0033	107

Issued on this 2nd day of June, 2014

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

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) :	MICHELLE WARRENER (107), BARBARA NAYKALYK-HUNT (146), ROBIN MACKIE (511), THERESA MCMILLAN (526)
Inspection No. / No de l'inspection :	2014_191107_0009
Log No. / Registre no:	H-000379-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 14, May 21, 2014
Licensee / Titulaire de permis :	NIAGARA HEALTH SYSTEM 63 THIRD STREET, WELLAND HOSPITAL SITE, WELLAND, ON, L3B-4W6
LTC Home / Foyer de SLD :	NIAGARA HEALTH SYSTEM, WELLAND HOSPITAL SITE, EXTENDED CARE UNIT 155 Ontario Street, St. Catharines, ON, L2R-5K3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	HELEN FERLEY

To NIAGARA HEALTH SYSTEM, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee shall cease using the tub lifts located in the North West wing and the North East wing, until they have been repaired and inspected for condition and safety by a qualified individual with experience in repairing tub lift equipment.

Grounds / Motifs :

1. The licensee did not ensure that procedures were developed and implemented to ensure that electrical and non-electrical equipment, specifically mechanical tub lifts and tubs were kept in good repair and maintained at a level that met manufacturer specifications.
A) Two non-electrical/non-mechanical tubs with accompanying mechanical tub lifts were available for use in the home on April 14, 2014. According to the Administrator and Personal Support Workers, the tubs in the North West and North East wings, and the accompanying lifts, were original to the home. A copy of the manufacturer's specifications for the tubs and tub lifts were not available for review in the home.
B) In the North West tub room, and in the IC0108 tub room, safety straps on the seat of the lift were frayed and in poor repair.
C) The North East tub lift had a small one inch by two inch piece of paper taped to the lift stating, "Do not lift chair past red ball". The red ball was suspended from the ceiling. A Personal Support Worker interviewed was unaware of the reason for the signage and red ball and proceeded to raise the lift to the red ball. The chair immediately ceased in the raised position and was unable to be lowered. A call to maintenance was placed by the RPN on duty at 1305 hours and a maintenance worker arrived to fix the lift. During interview, the maintenance worker did not believe the lift had been inspected and the red ball was a corrective measure for the malfunctioning of the lift. The maintenance worker stated the red ball/signage had been in place for approximately 10 years.

D) The Environmental Services Supervisor was not aware that the tub lifts and tubs had not been inspected routinely as part of the home preventive maintenance program.
E) No records were available to confirm the lifts had been inspected for safe resident use and the Administrator and Environmental Manager confirmed that the lifts were not being inspected.
F) The home did not have any procedures in place to address how the tubs and tub lifts would be maintained, repaired, inspected and by whom and how often. Personal support workers who were interviewed had not been directed to inspect the belts for condition on a daily basis.

G) Two Personal Support Workers confirmed that residents were routinely bathed in the tub in both wings using the bath chairs.
H) A non-electrical/non mechanical tub in the North West tub room was in disrepair. The surface of the rim of the tub's left side (facing the head of the tub) and the bottom of the tub near the drain was not smooth and was not easy to clean. Staff confirmed that the tub was used daily. (107)

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_191107_0009, CO #901;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for ensuring that electrical and non-electrical equipment, including mechanical lifts are kept in good repair. The home shall establish a procedure that addresses how the tub lifts and tubs are to be maintained, repaired, and inspected and include who will be responsible for the task and how often. The plan shall also include how the home will ensure that procedures were developed and implemented for all plumbing, fixtures, toilets, sinks, grab bars, and washroom fixtures are maintained and kept free of corrosion and cracks. The plan shall be implemented.
The plan shall be submitted by June 4, 2014 to Long-Term Care Homes Inspector Michelle Warrener, at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O.Reg. 79/10, s. 90(2)(a)]
The licensee did not ensure that procedures were developed and implemented to ensure that electrical and non-electrical equipment, specifically mechanical tub lifts and tubs were kept in good repair and maintained at a level that met manufacturer specifications.
A) Two non-electrical/non-mechanical tubs with accompanying mechanical tub lifts were available for use in the home on April 14, 2014. According to the Administrator and Personal Support Workers, the tubs in the North West and North East wings, and the accompanying lifts, were original to the home. A copy of the manufacturer's specifications for the tubs and tub lifts were not available for review in the home.
B) In the North West tub room, and in the IC0108 tub room, safety straps on the seat of the lift were frayed and in poor repair.
C) The North East tub lift had a small one inch by two inch piece of paper taped to the lift stating, "Do not lift chair past red ball". The red ball was suspended from the ceiling. A Personal Support Worker interviewed was unaware of the reason for the signage and red ball and proceeded to raise the lift to the red ball. The chair immediately ceased in the raised position and was unable to be lowered. A call to maintenance was placed by the RPN on duty at 1305 hours and a maintenance worker arrived to fix the lift. During interview, the maintenance worker did not believe the lift had been inspected and the red ball was a corrective measure for the malfunctioning of the lift. The maintenance worker stated the red ball/signage had been in place for approximately 10 years.

D) The Environmental Services Supervisor was not aware that the tub lifts and tubs had not been inspected routinely as part of the home preventive maintenance program.
E) No records were available to confirm the lifts had been inspected for safe resident use and the Administrator and Environmental Manager confirmed that the lifts were not being inspected.
F) The home did not have any procedures in place to address how the tubs and tub lifts would be maintained, repaired, inspected and by whom and how often. Personal support workers who were interviewed had not been directed to inspect the belts for condition on a daily basis.
G) Two Personal Support Workers confirmed that residents were routinely bathed in the tub in both wings using the bath chairs.
H) A non-electrical/non mechanical tub in the North West tub room was in disrepair. The surface of the rim of the tub's left side (facing the head of the tub) and the bottom of the tub near the drain was not smooth and was not easy to clean. Staff confirmed that the tub was used daily. [s. 90. (2) (a)] (107)

2. [O.Reg. 79/10, s. 90(2)(d)]
The licensee did not ensure that procedures were developed and implemented to ensure that all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.
A)On April 11, 2014 the South West and North West shower room tubs were observed to have the finish coming off of the bottom, near the drain, and top left side of tub. There were water stains on the ceiling tiles of the South West room and there was extensive staining of the shower room floors. On the bottom corners of the South West, North West and North East shower hard surface baseboards, there was moderate damage to the corners where the baseboard corners were cracked and corroded metal strips were exposed. Interview with the Environmental Manager/Hospitality on April 15, 2014 confirmed disrepair of the baseboard, tubs and shower floors was unacceptable by the home's standard and that the home did not ensure that procedures were developed and implemented to ensure that all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks. [s. 90. (2) (d)] (511)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2014

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2013_105130_0033, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the home's Nutrition/Dietary Services and Skin/Wound Management policies and procedures are complied with.
The plan shall be submitted by June 4, 2014 to Long-Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O.Reg. 79/10, s. 8(1)(b)]
The licensee did not ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy, or system, was complied with.
A) The home's Nutrition Care and Hydration Programs policy stated that the nursing department and Food Services Supervisor were to refer residents with identified nutritional and hydration issues to the Dietitian for further assessment. Residents were not consistently referred to the Dietitian when their nutrition goals were not met or when their status changed. Both dietary and nursing staff confirmed that the Dietitian referral system was not consistently used for the communication of nutritional concerns to the Registered Dietitian. (107)
B) The home's Med Pass Program stated the Registered Dietitian would determine the particular resident's energy/protein needs and prepare a plan of

care. The Registered Dietitian did not determine each resident's current energy, protein, or fluid needs in relation to the Med Pass orders for resident #137. (107)

C)The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with specifically related to the home's Skin and Wound Management policy #S-10 which was revised on January 2014.

i) The policy stated that "Bath nurses complete head to toe skin inspections and document (weekly) reporting findings accurately to the RN/RPN for follow up". Staff indicated that skin assessments were located either in the bath binder or the resident's health record. Weekly skin assessments were not completed/documented between over a 49 day period for resident #117. Skin Inspection tools (Bath day) for resident #129 were not found for a 36 day period. Staff confirmed that skin assessments were not documented if the bath sheet was not completed. (526)

ii) The policy stated that the RN and RPN "Reviews bath day skin care assessment tool and provides direction to the PSW/HCAs". Skin Inspection tools (Bath day) for resident #117 did not contain registered staff signatures for tools completed by PSW/HCA's on five occasions over a two month period. Registered staff confirmed that they did not consistently review the bath sheets as per the policy. (526)

iii) The policy stated that the RN and RPN "initiates referrals and consults with members of the interdisciplinary team". Staff confirmed that Resident #117's progress notes indicated the resident had open areas on their skin. The registered staff and Registered Dietitian confirmed that referrals to the Registered Dietitian were not made consistently and confirmed that resident #117 had not been referred to the Registered Dietitian as the result of the skin integrity issue identified over a one month period. (526)

Resident #129 progress notes indicated that altered skin integrity was observed over a two month period. The Registered Dietitian confirmed that she did not receive a referral regarding resident #129. (526)

iv) The policy stated that the RN and RPN "implements a plan of care in accordance with the skin protocols of the home". Resident #117 presented with altered skin integrity over a two month period. No nursing entry in the resident's care plan following the identification of these skin integrity issues was found. Staff confirmed that nursing specific care plan for resident #117 could not be found. (526) [s. 8. (1) (b)] (107)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2014

Order # / Ordre no : 003

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan that ensures written plans of care provide clear direction to staff and others providing care to residents. This includes direction related to catheter care, oral care, and the operation of power wheelchairs and consistencies between the kardex and plan of care.
The plan shall be submitted by June 4, 2014 to Long-Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)]
The licensee did not ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to residents.
A) The written care plan for resident #155 provided specific direction for staff related to a mobility device, however, a note posted at the back of the resident's bed provided different direction. The PSW's giving care to the resident stated they followed the one posted at the bedside. The directions to staff related to the resident's mobility device were unclear. (146)
B) On April 11, 2014 resident #126 was observed to have a medical device in place. Direction provided to staff related to the medical device was not consistent or clear between the resident's MDS Kardex in hard copy, the most recent care plan, printed April 23, 2014, Physician's order and Treatment Administration record (TAR) printed April 11, 2014. Interview with the registered staff on April 11, 2014 confirmed the written plan of care did not provide clear direction to staff and others who provided direct care to the resident. (511)
C) Resident #121's care plan directed staff to do mouth care twice daily. The resident's kardex directed staff to do mouth care daily. This information was confirmed by staff and the health record. (146)
D) Resident #131's care plan directed staff to do mouth care after meals and at bedtime, which would be four times per day. The resident's kardex directed staff to do mouth care daily. (146)
E) The plan of care for resident #129 did not provide clear directions in relation to oral hygiene. The plan for oral hygiene identified that the resident required assistance with oral hygiene, however, did not identify the required frequency for staff to assist with oral hygiene, did not identify that the resident wore dentures, and did not identify that the resident did not have their own teeth. Staff interviewed were unable to tell inspector by reviewing the plan of care if the resident had teeth in addition to dentures or dentures only and confirmed that the plan of care should have included clearer direction related to the resident's oral hygiene needs.(107) [s. 6. (1) (c)] (511)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 004

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

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 shall prepare, submit and implement a plan that ensures 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 plan shall be submitted by June 4, 2014 to Long-Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 8(3)]
The licensee did not ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times.
A) A review of staffing schedules from March 24 to April 20, 2014 was conducted and indicated that at least one RN, excluding the Director of Care (DOC), was not present during at least ten shifts in this time period including the following: evening shifts on March 25, 28, 30, April 1, 5, and 6, 2014; and night shifts on April 7, 8, 12, and 13, 2014. The staffing clerk and Administrator confirmed that an RN was not on duty and present in the home during the identified shifts between March 24 and April 20, 2014. [s. 8. (3)] (526)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2014

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan that ensures that where bed rails are used the resident is assessed and their bed system is evaluated in accordance with evidence-based practices and steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.
The plan shall be submitted by May 26, 2014 to Long-Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O.Reg. 79/10, s. 15(1)(a)]
Where bed rails were used, not all bed systems were evaluated in accordance with evidence-based practices to minimize risk to residents.
A) The home commissioned a person to complete a bed entrapment zone audit of all the resident bed systems in 2012. The results of the audit did not identify if any of the home's beds failed one or more zones of entrapment which could potentially cause injury to the resident and did not include a record for all of the beds in the home. Only a small percentage of beds had data available. The monitoring tool that the home kept on record for each bed did not identify any of the zone entrapment hazard potential. (107)
B) During a tour of the home, some gaps between the bed rails and mattresses were observed. These areas were not those identified as part of the audit or were on beds that were changed after the audit without a re-assessment of the safety zones. The home had a mix of bed models and mattresses of different ages. Some beds were furnished with quarter length assist bed rails and others with older full length rails. A number of bed frames had missing mattress keepers or they were not in place to keep the mattresses from sliding side to side. When beds without mattress keepers were tested, the mattresses easily slid off the frame of the bed. (107)
C) The Administrator confirmed the home did not have a process in place to identify which mattresses had been changed or replaced since the audit in 2012 and that new beds were received in 2013. The new beds did not receive a post entrapment zone assessment to determine if the new beds and mattresses were compliant with entrapment zone safety. (107)
D) Documentation in the progress notes for resident #139 stated that the resident got stuck between their mattress and bed rails. There was no evidence to support that the resident's mattress had been assessed for safety prior to or after the incident. (107)
E) Resident #126 was interviewed and confirmed the staff put two bed rails up on their bed when they went to sleep at night. Resident #126's bed rails were observed to be full bed rails. Review of the clinical records and interview with the DOC confirmed the home did not assess the resident and evaluate their bed system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. (511) [s. 15. (1) (a)] (107)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 01, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that ensures the dietary services and hydration program includes interventions to mitigate and manage risks related to diet texture changes.
The plan shall be submitted by June 4, 2014 to Long-Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O.Reg. 79/10, s. 68(2)(c)]
The nutrition care and hydration programs did not include the implementation of interventions to mitigate and manage the identified risks related to nutrition care and dietary services and hydration.
A) A system was not in place under the food services and hydration program to ensure that residents requiring diet texture or fluid consistency changes received an assessment, including risk management strategies for trial diets. The current system did not include an assessment of risk, abilities, causal factors, feeding/swallowing strategies, etc. prior to the implementation of a trial diet texture and did not differentiate between diet texture upgrades and downgrades. Three of three residents (#131, #119, #126) reviewed with diet texture changes did not have an assessment prior to the implementation of the texture upgrade. [s. 68. (2) (c)] (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2014

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures residents are provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
The plan shall be submitted by June 4, 2014 to Long-Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O.Reg. 79/10, s. 73(1)9]
Not all residents were provided with eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible at the lunch meal April 8, 2014.
A) Resident #141 required cueing, encouragement, or total assistance with eating if needed. The resident was not assisted with their meal and was struggling to eat independently. The resident's assistive device was positioned incorrectly and did not allow the resident to use the adaptive aid to assist with eating. The resident was observed pushing the food off the plate and unable to get the food on the spoon. The resident was left in the dining room at the end of the meal and was not assisted until 1320 hours (the lunch meal began at 1200 hours). The resident ate when being fed by staff.
B) Resident #142 required cueing and encouragement at meals and assistance from staff when unable to feed themselves. The resident sat sleeping in-front of their soup from 1210 hours to 1218 hours when verbal prompting was provided. The resident was served their entree at 1227 hours, however, sat without eating until 1251 hours when their entree was cleared (virtually untouched) and dessert was placed on the table and the resident sat in-front of their dessert until 1309 hours when the dessert was cleared and not consumed. Staff did not physically assist the resident with eating and the resident was not feeding themselves.
C) Resident #135 did not receive the required level of assistance with eating their soup. The soup was placed in-front of the resident who sat without assistance being provided. The resident then attempted to grab the mug of soup, however, tipped the cup over and spilled the soup on the table. The soup was cleared away, however, a replacement for the soup was not provided. The resident was assisted by staff with their entree when an additional staff member arrived at the table.
D) Resident #133 required cueing and encouragement and total assistance with eating. The resident sat not eating at 1311 hours. The resident took one spoonful of dessert, however, did not continue eating. The resident was not assisted with their dessert and did not eat it.
E) Assistive devices were not available on the afternoon snack cart April 16, 2014. Resident #156 required a sippy cup at meals and snacks. Staff interviewed stated assistive devices are not routinely placed on the snack cart and staff are required to go get them as needed from the servery. [s. 73. (1) 9.] (107)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that drugs are stored in an area or a medication cart that is secure and locked.

Grounds / Motifs :

1. [O.Reg. 79/10, s. 129(1)(a)(ii)]
The licensee did not ensure that drugs were stored in an area or a medication cart that was secure and locked.
A) On April 23, 2014 at 1600 hours, a medication cart was observed in the hallway unattended and with drawers unlocked and one slightly ajar. A resident was sitting in a wheelchair in the hallway four metres away. The monitor and the electronic MAR were also open and in full view with resident name, room number and medication names in full view. The medication nurse was in a resident room and not within view of the unsecured medication cart or the resident sitting nearby. The DOC was alerted, locked the cart, closed the electronic screen and confirmed that this was an unacceptable practice. (146)
B) On April 8, 9, 10, 11 and 14, 2014 topical medications were observed on the top of the treatment cart in the nursing station of a specific wing and not secured and locked; registered staff and DOC confirmed that the medications should have been in a locked location. (146)
C) On April 8, 2014 at 1530 hours inspectors observed an unlocked medication cart in the hallway and not within view of the RPN staff. (146)
D) April 14, 2014, during a medication pass observation RPN staff were observed to leave the medication cart unlocked in hallway while they administered medications in the dining room between 1230 and 1250 hours. Drugs were not stored in an area or medication cart that was consistently secure or locked. (526)
C) On April 24, 2014 at 1600 hours, the inspectors observed an unlocked unattended medication cart outside a room. Staff was providing care to a resident in the room and did not have a visual sight-line to the cart. The registered staff member returned to the cart and said they had thought that they had locked the cart and were aware that the cart should have been locked. (107) (146)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2014

Order # / Ordre no : 009

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

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 shall prepare, submit and implement a plan that ensures that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment; 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 is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. The plan shall be submitted by June 4, 2014 to Long-Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O.Reg. 79/10, s. 50(2)(b)(i)]
The licensee did not ensure that a resident exhibiting altered skin integrity, including skin breakdown, ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument.
A) The licensee did not ensure that resident #119 who exhibited a wound received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. Registered staff confirmed that they did not assess the wound using a clinically appropriate assessment tool. There was no evidence of the skin assessment in progress notes where staff had indicated that the wound note would have been found.
B)Registered staff confirmed that the home's accepted clinically appropriate assessment in a "Wound/treatment progress note" included "Location and brief description of the area being treated; size/stage/depth, discharge (include amount and description); progress (indicate status, improvement or worsening); evidence of infection /action taken, indicate referral, eg. Physician, dietitian, physiotherapist". Staff confirmed that all skin and wound assessments were located in the progress notes.
C) Resident #129 exhibited an alteration in skin integrity, however, skin and wound incidents were not assessed.(526)
D)Resident #137 had altered skin integrity noted in the progress notes. Registered nursing staff confirmed that the skin assessment tool that the home used to document skin and wound assessments was a progress note specifically for skin and wound assessments. An assessment, using the home's progress note form, was not completed for the areas. Staff confirmed that the areas were

not assessed by a member of the registered nursing staff and was not documented in the home's progress notes. (107)
E) The Skin inspection tool (bath day) records for resident #139 identified concerns with skin integrity. Registered staff interviewed stated that the skin assessments were to be recorded in the progress notes on the specific template for wounds. Documentation in the progress notes did not reflect an assessment of the open area by a member of the registered nursing staff using the specified progress note. (107) [s. 50. (2) (b) (i)]
(526)

2. [O.Reg. 79/10, s. 50(2)(b)(iii)]
The licensee did not ensure that a resident who exhibited altered skin integrity including skin breakdown, pressure ulcers, skin tears and wounds had been assessed by a Registered Dietitian who was a member of the staff of the home.
A) Resident #117's progress notes indicated the resident had altered skin integrity. Progress notes, dietary assessment forms, registered staff and the Registered Dietitian confirmed that a Registered Dietitian did not assess the resident on these two occasions when alteration in skin integrity was noted. (526)
B)Resident #139, who was exhibiting altered skin integrity, was not assessed by a Registered Dietitian and changes were not made to the plan of care related to nutrition and hydration.
i) Documentation in the resident's progress notes identified concerns with skin integrity. The resident was seen by the Dietitian for the quarterly review, however, the review did not include an assessment of the resident's skin or a re-assessment of the resident's nutritional requirements related to the skin impairment or significant weight loss. The Dietitian confirmed that she was not aware of the resident's skin integrity issues.
ii) The skin observation sheets completed by Personal Support Workers (PSWs) identified concerns with skin integrity. The resident was not assessed by the Dietitian in relation to the resident's poor skin integrity with an assessment of the resident's nutritional requirements in relation to the identified areas of skin breakdown. (107)
C) Resident #129 was noted to have an alteration of skin integrity. No Registered Dietitian progress notes or assessments were found regarding the areas. The home's Registered Dietitian confirmed that resident #129 did not receive a dietary assessment in response to skin integrity concerns. (526)
D) Resident #137 was not assessed by the Registered Dietitian in relation to impaired skin integrity. The Dietitian ordered a nutritional supplement, however,

an assessment in related to skin impairment was not completed/documented. (107) [s. 50. (2) (b) (iii)] (107)

3. [O.Reg. 79/10, s. 50(2)(b)(iv)]
The licensee did not ensure that a resident who exhibited altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered staff.
A) Registered staff confirmed that skin care assessments were documented in the progress notes using the Point-click-care online documentation. The progress notes for resident #117 identified skin integrity concerns. The progress notes did not contain evidence of weekly skin assessments following the identification of the poor skin integrity over a three month period. A registered staff confirmed that resident #117's altered skin integrity was not reassessed by a registered nursing staff at least weekly following the initial assessments of the skin areas. (526)
B) Resident #137, exhibiting altered skin integrity, was not reassessed at least weekly by a member of the registered nursing staff for multiple areas of concern on the resident's skin. One area was not re-assessed by a member of the registered nursing staff until it was noted there was a significant worsening of the area. Staff confirmed that the area was not reassessed at least weekly by a member of the registered nursing staff and that weekly assessment of the area was indicated. Other areas of skin integrity concerns were noted, however, there was no re-assessment of the areas by a member of the registered nursing staff. Staff confirmed that weekly re-assessment by the registered nursing staff was not completed for these areas. (107)
C) Resident #139 was not reassessed at least weekly by a member of the registered staff in relation to skin integrity concerns. Registered staff interviewed stated skin assessments were to be completed in the progress notes under the specific progress note for wounds. Skin assessments were not completed weekly by the registered staff in relation to the open area. (107) [s. 50. (2) (b) (iv)] (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2014

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

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 14th day of April, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MICHELLE WARRENER

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