Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 22, 2016	2016_248214_0014	009297-16;009302-16	Follow up

Licensee/Titulaire de permis

MARYBAN HOLDINGS LTD
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

OAKWOOD PARK LODGE
6747 OAKWOOD DRIVE NIAGARA FALLS ON L2E 6S5

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

CATHY FEDIASH (214)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 6, 7, 11, 2016.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC); registered staff; Personal Support Workers (PSW); activation/recreation staff; Food Service Manager (FSM); Resident Assessment Instrument (RAI) Coordinator and residents. During the course of this inspection, the Inspector observed a meal service; reviewed residents clinical records; reviewed relevant policies and procedures; reviewed staff training records and observed residents in dining and care areas.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Pain
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of the home's policy titled, "Documentation" (CN-D-19-1 and dated April 2011) stated "PSW must document intake of food and fluid for all meals and snacks on Nutritional Flow Chart" and "It is important to complete these accurately and in detail to ensure accurate accounting of resident intake".

An interview with the DOC indicated that the home had made a revision to their policy on an identified date in 2016, with regards to the area of "oral intake of food" when requesting a nutritional assessment by the Registered Dietitian (RD). During an interview with the FSM, a copy of the home's Diet Requisition was provided which identified the oral intake of food revision. The FSM indicated that the home did not keep the paper Diet Requisition referral forms, once reviewed by the RD and that a progress note was completed in the resident's clinical record by the FSM or RD that identified a referral form was received and the actions taken in response.

A review of the Diet Requisition referral form identified examples of reasons to refer to the RD would include the following:

a) Oral Intake of Fluid Routinely Below 1000 millilitres (ml) / Day for 5 Consecutive days
b) Oral Intake of Food: - leaves 25 percent (%) or more, 2 out of 3 meals over 7 days

A) A review of resident #111's Nutritional Flow Chart was conducted for a period of 27 consecutive days in 2016. It was documented that for five consecutive days during the review period, the resident's total volume of fluids consumed were less than 1000 ml per day for the five consecutive days. A review of documentation for the resident's food intake identified that for nine consecutive days during the review period, the resident left 25% or more of food at two out of three meals.

A review of resident #111's clinical records did not include a diet requisition referral form or documentation that a diet requisition referral form had been completed. An interview with the FSM on an identified date in 2016, confirmed that a diet requisition form had not been completed when the resident's oral intake of fluids was routinely below 1000 ml per day for five consecutive days and had not been completed when the resident left 25% or more of food at two out of three meals over a nine day consecutive period. The FSM

confirmed that the home had not complied with their policy.

B) A review of resident #112's Nutritional Flow Chart was conducted for a period of 10 consecutive days in 2016. It was documented that for six consecutive days during the review period, the resident's total volume of fluids consumed were less than 1000 ml per day for six consecutive days. A review of documentation for the resident's food intake identified that for 10 consecutive days during the review period, the resident left 25% or more of food at two out of three meals.

A review of resident #112's clinical records did not include a diet requisition referral form or documentation that a diet requisition referral form had been completed. An interview with the FSM on an identified date in 2016, confirmed that a diet requisition form had not been completed when the resident's oral intake of fluids was routinely below 1000 ml per day for six consecutive days and had not been completed when the resident left 25% or more of food at two out of three meals over a 10 day consecutive period. The FSM confirmed that the home had not complied with their policy.

PLEASE NOTE: This non compliance was identified during Follow Up Inspection log#009297-16. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: 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,
(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).

Findings/Faits saillants :

1. The licensee failed to ensure that, (d) any resident who was dependent on staff for repositioning was 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.

A) A review of resident #104's clinical record was conducted. The resident's current kardex indicated under mobility and bed mobility that the resident was to be turned and repositioned every two hours.

A review of the resident's current written plan of care indicated under mobility and bed mobility that the resident was to be turned and repositioned every two hours.

A review of a paper form titled, "Turning and Repositioning Record" and located in the resident's flow sheet documentation binder, indicated that the resident was to be repositioned every two hours while awake and only when sleeping if clinically indicated.

On an identified date in 2016, the resident was observed from 0830 hours until 1125 hours. The resident was observed to be seated in their mobility aid in the dining room until 1000 hours when they were assisted to a music program. The resident was not observed to be repositioned during this time frame. The resident was observed to be in attendance at a music program until they were assisted back to their unit at 1105 hours. The resident was not observed to be repositioned since returning back to the unit and up to and including 1125 hours.

An interview with PSW staff #003 confirmed that they were assigned to the resident's care on this identified date in 2016 and that the resident was to be repositioned every two hours. The staff member indicated that the resident had been assisted to the dining room at approximately 0800 hours and not repositioned from this time until the time of

the interview at 1140 hours. The staff member confirmed that the resident had not been repositioned every two hours as required.

B) A review of resident #105's clinical record was conducted. The resident's current kardex indicated under mobility that staff were to follow the turning and repositioning routine to ensure comfort and skin maintenance.

A review of the resident's current written plan of care indicated under alteration to skin that staff were to follow the turning and repositioning routine to ensure comfort and skin maintenance.

A review of a paper form titled, "Turning and Repositioning Record" and located in the resident's flow sheet documentation binder, indicated that the resident was to be repositioned every two hours while awake.

On an identified date in 2016, the resident was observed from 0830 hours until 1125 hours to be seated in their mobility aid in the dining room. The resident was not observed to be repositioned during the identified time frame.

An interview with PSW staff #003 confirmed that they were assigned to the resident's care on this identified date in 2016 and that the resident was to be repositioned every two hours. The staff member indicated that the resident had been assisted to the dining room at approximately 0800 hours and not repositioned from this time until the time of the interview at 1140 hours. The staff member confirmed that the resident had not been repositioned every two hours as required.

C) A review of resident #106's clinical record was conducted. The resident's current kardex indicated under mobility that the resident was to be turned and repositioned every two hours.

A review of the resident's current written plan of care indicated under mobility that the resident was to be turned and repositioned every two hours.

A review of a paper form titled, "Turning and Repositioning Record" and located in the resident's flow sheet documentation binder, indicated that the resident was to be repositioned every two hours while awake and only when sleeping if clinically indicated.

On an identified date in 2016, the resident was observed from 0830 hours until 1125

hours to be seated in their mobility aid. Following their breakfast, the resident was observed wandering about the unit in their mobility aid. The resident was not observed to be repositioned during the observed time frame.

An interview with PSW staff #002 confirmed that they were assigned to the resident's care on this identified date in 2016 and that the resident was to be repositioned every two hours. The staff member indicated that the resident had been assisted to the dining room at approximately 0800 hours and was not repositioned from this time until the time of the interview at 1140 hours. The staff member confirmed that the resident had not been repositioned every two hours as required.

PLEASE NOTE: The above noted non-compliance was identified while conducting Follow Up Inspection #009302-16. [s. 50. (2) (d)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of the home's document, titled, "Medical Directives for Hypo/Hyperglycemia"

stated that when a resident's blood glucose level was less than 4 mmol/L (millmole per litre), the RPN was required to administer one of the following choices:

Medication/Treatment
a) 175 millilitres (mls) apple or cranberry juice or regular pop
b) 3 teaspoons (15ml) or 3 packets of sugar dissolved in 2 ounces (60 ml) of water
c) 1 tablespoon (15ml) of honey
d) 3 Glucose tablets

The follow up action was that the RPN was to notify the RN of the blood glucose level and treatment administered (above) as well as retesting the blood glucose in 20 minutes. If the blood glucose level was still below 4 mmol/L the RPN was to consult with the RN and repeat treatment. They may repeat as necessary until blood glucose was above 4 mmol/L.

A review of resident #108's clinical record indicated that on an identified date in 2016, the resident's blood glucose level was documented to have been 3.1 mmol/L at 0708 hours. The clinical record also indicated that five days later, the resident's blood glucose level was documented to have been 3.9 mmol/L at 0800 hours.

A review of the resident's clinical records indicated that no documentation had occurred for the two identified dates in 2016, with regards to what medication/treatment intervention had been provided to the resident when their blood glucose levels were below 4 mmol/L. No documentation was observed that identified the follow up action of notifying the Registered Nurse (RN) of the blood glucose level and treatment administered.

An interview with registered staff #004 on an identified date in 2016, indicated that on the second date identified in 2016, the resident was provided with the intervention of 3 packages of sugar and that the registered nurse was notified of the blood glucose level and the treatment administered. The staff member indicated and documentation confirmed that blood glucose levels were retested and were above 4 mmol/L. The staff member confirmed that actions taken with respect to interventions provided as directed in the home's Medical Directives for hypoglycemia had not been documented.

An interview with registered staff #005 on an identified date in 2016, indicated that on the first date identified in 2016, the resident was provided with the intervention of 175 ml of apple juice and that the registered nurse was notified of the blood glucose level and the

treatment administered. The staff member indicated and documentation confirmed that blood glucose levels were retested and were above 4 mmol/L. The staff member confirmed that actions taken with respect to interventions provided as directed in the home's Medical Directives for hypoglycemia had not been documented. [s. 30. (2)]

Additional Required Actions:

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

Issued on this 16th day of August, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CATHY FEDIASH (214)
Inspection No. / No de l'inspection :	2016_248214_0014
Log No. / Registre no:	009297-16;009302-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jul 22, 2016
Licensee / Titulaire de permis :	MARYBAN HOLDINGS LTD 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	OAKWOOD PARK LODGE 6747 OAKWOOD DRIVE, NIAGARA FALLS, ON, L2E-6S5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Stephen Moran

To MARYBAN HOLDINGS LTD, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_214146_0004, 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 following policies are complied with:

1) "Documentation" (CN-D-19-1 and dated April 2011) including the referenced form, "Nutritional Flow Chart" contained in this policy.

2) Any other home policies and forms which direct staff of when to complete a dietary referral to the Registered Dietitian.

The plan is to include, but not limited to the following:

1) Mandatory training to all staff who are responsible for completing a dietary referral on the "Documentation" policy including the referenced form, "Nutritional Flow Chart" contained in this policy.

2) Mandatory training to all staff who are responsible for completing a dietary referral for any other home policies and forms which direct staff when to complete a dietary referral to the Registered Dietitian.

3) The licensee shall conduct auditing activities of resident's clinical records at a frequency and schedule as they determine to ensure that resident's are referred to the Registered Dietitian as identified in the home's policies and forms.

The plan is to be submitted on or before August 19, 2016, to Cathy Fediash at Cathy.Fediash@ontario.ca

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (2) and compliance history (4), in keeping with r.8(1)(b) of the Ontario Regulation 79/10, in respect of the potential for harm to all resident's with a nutrition and hydration risk, the scope of "pattern" within the context of a Follow Up Inspection, and the Licensee's history of ongoing non-compliance (CO) on July 27, 2015 and March 9, 2016,Resident Quality Inspection's related to r.8(1)(b).

The licensee failed to ensure that any plan, policy protocol, procedure, strategy or system was complied with.

A review of the home's policy titled, "Documentation" (CN-D-19-1 and dated

April 2011) stated "PSW must document intake of food and fluid for all meals and snacks on Nutritional Flow Chart" and "It is important to complete these accurately and in detail to ensure accurate accounting of resident intake".

An interview with the DOC indicated that the home had made a revision on an identified date in 2016 to the policy with regards to the area of "oral intake of food" when requesting a nutritional assessment by the Registered Dietitian (RD). During an interview with the FSM, a copy of the home's Diet Requisition was provided which identified the oral intake of food revision. The FSM indicated that the home did not keep the paper Diet Requisition referral forms, once reviewed by the RD and that a progress note was completed in the resident's clinical record by the FSM or RD that identified a referral form was received and the actions taken in response.

A review of the Diet Requisition referral form identified examples of reasons to refer to the RD would include the following:

a) Oral Intake of Fluid Routinely Below 1000 millilitres (ml) / Day for 5 Consecutive days
b) Oral Intake of Food: - leaves 25 percent (%) or more, 2 out of 3 meals over 7 days

A) A review of resident #111's Nutritional Flow Chart was conducted for a period of 27 consecutive days in 2016. It was documented that for five consecutive days during the review period, the resident's total volume of fluids consumed were less than 1000 ml per day for the five consecutive days. A review of documentation for the resident's food intake identified that for nine consecutive days during the review period, the resident left 25% or more of food at two out of three meals.

A review of resident #111's clinical records did not include a diet requisition referral form or documentation that a diet requisition referral form had been completed. An interview with the FSM on an identified date in 2016, confirmed that a diet requisition form had not been completed when the resident's oral intake of fluids was routinely below 1000 ml per day for five consecutive days and had not been completed when the resident left 25% or more of food at two out of three meals over a nine day consecutive period. The FSM confirmed that the home had not complied with their policy.

B) A review of resident #112's Nutritional Flow Chart was conducted for a period of 10 consecutive days in 2016. It was documented that for six consecutive days during the review period, the resident's total volume of fluids consumed were less than 1000 ml per day for six consecutive days. A review of documentation for the resident's food intake identified that for 10 consecutive days during the review period, the resident left 25% or more of food at two out of three meals.

A review of resident #112's clinical records did not include a diet requisition referral form or documentation that a diet requisition referral form had been completed. An interview with the FSM on an identified date in 2016, confirmed that a diet requisition form had not been completed when the resident's oral intake of fluids was routinely below 1000 ml per day for six consecutive days and had not been completed when the resident left 25% or more of food at two out of three meals over a 10 day consecutive period. The FSM confirmed that the home had not complied with their policy.

PLEASE NOTE: This area of non-compliance was identified during Follow Up inspection, log #009297-16.
(214)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 28, 2016

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_214146_0004, CO #002;

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 to ensure that any resident who is dependent on staff for repositioning including resident #104, 105 and 106, 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.

The plan is to include, but not limited to the following:

1) Mandatory training to all staff who are responsible for repositioning a resident who is dependent upon staff for repositioning that includes but is not limited to re-education on the home's Turning and Repositioning Record.

2) The licensee shall conduct auditing activities that include but are not limited to the following:

a) The observations of resident's who are dependent on staff for repositioning, ensuring they are repositioned every two hours or more frequently as required and while asleep if clinically indicated at a frequency and schedule as they determine.

b) Review of resident's Turning and Repositioning Records at a frequency and schedule as they determine to ensure that resident's who are dependent on staff for repositioning are repositioned every two hours or more frequently as required and while asleep if clinically indicated.

The plan is to be submitted on or before August 19, 2016, to Cathy Fediash at Cathy.Fediash@ontario.ca

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (3) and compliance history (4), in keeping with r.50(2)(d) of the Ontario Regulation 79/10, in respect of the potential for harm to residents #104, 105 and 106, the scope of "widespread" within the context of a Follow Up Inspection, and the Licensee's history of ongoing non-compliance (CO) on July 27, 2015 and March 9, 2016, Resident Quality Inspection's related to r.50(2)(d).

The licensee failed to ensure that, (d) any resident who was dependent on staff for repositioning was 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.

A) A review of resident #104's clinical record was conducted. The resident's current kardex indicated under mobility and bed mobility that the resident was to be turned and repositioned every two hours.

A review of the resident's current written plan of care indicated under mobility and bed mobility that the resident was to be turned and repositioned every two hours.

A review of a paper form titled, "Turning and Repositioning Record" and located in the resident's flow sheet documentation binder, indicated that the resident was to be repositioned every two hours while awake and only when sleeping if clinically indicated.

On an identified date in 2016, the resident was observed from 0830 hours until 1125 hours. The resident was observed to be seated in their mobility aid in the dining room until 1000 hours when they were assisted to a music program. The resident was not observed to be repositioned during this time frame. The resident was observed to be in attendance at a music program until they were assisted back to their unit at 1105 hours. The resident was not observed to be repositioned since returning back to the unit and up to and including 1125 hours.

An interview with PSW staff #003 confirmed that they were assigned to the resident's care on this identified date in 2016 and that the resident was to be repositioned every two hours. The staff member indicated that the resident had been assisted to the dining room at approximately 0800 hours and not repositioned from this time until the time of the interview at 1140 hours. The staff member confirmed that the resident had not been repositioned every two hours as required.

B) A review of resident #105's clinical record was conducted. The resident's current kardex indicated under mobility that staff were to follow the turning and repositioning routine to ensure comfort and skin maintenance.

A review of the resident's current written plan of care indicated under alteration to skin that staff were to follow the turning and repositioning routine to ensure

comfort and skin maintenance.

A review of a paper form titled, "Turning and Repositioning Record" and located in the resident's flow sheet documentation binder, indicated that the resident was to be repositioned every two hours while awake.

On an identified date in 2016, the resident was observed from 0830 hours until 1125 hours to be seated in their mobility aid in the dining room. The resident was not observed to be repositioned during the identified time frame.

An interview with PSW staff #003 confirmed that they were assigned to the resident's care on this identified date in 2016 and that the resident was to be repositioned every two hours. The staff member indicated that the resident had been assisted to the dining room at approximately 0800 hours and not repositioned from this time until the time of the interview at 1140 hours. The staff member confirmed that the resident had not been repositioned every two hours as required.

C) A review of resident #106's clinical record was conducted. The resident's current kardex indicated under mobility that the resident was to be turned and repositioned every two hours.

A review of the resident's current written plan of care indicated under mobility that the resident was to be turned and repositioned every two hours.

A review of a paper form titled, "Turning and Repositioning Record" and located in the resident's flow sheet documentation binder, indicated that the resident was to be repositioned every two hours while awake and only when sleeping if clinically indicated.

On an identified date in 2016, the resident was observed from 0830 hours until 1125 hours to be seated in their mobility aid. Following their breakfast, the resident was observed wandering about the unit in their mobility aid. The resident was not observed to be repositioned during the observed time frame.

An interview with PSW staff #002 confirmed that they were assigned to the resident's care on this identified date in 2016 and that the resident was to be repositioned every two hours. The staff member indicated that the resident had been assisted to the dining room at approximately 0800 hours and was not

repositioned from this time until the time of the interview at 1140 hours. The staff member confirmed that the resident had not been repositioned every two hours as required.

PLEASE NOTE: The above noted non-compliance was identified while conducting Follow Up Inspection #009302-16.
(214)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 28, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 22nd day of July, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CATHY FEDIASH

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