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 prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Mar 02, 2017;	2016_393606_0009 (A1)	016066-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE DISTRICT OF THE MUNICIPALITY OF MUSKOKA
98 Pine Street BRACEBRIDGE ON P1L 1N5

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

THE PINES
98 PINE STREET BRACEBRIDGE ON P1L 1N5

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

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JANET GROUX (606) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Section s. 24 has been revoked from the licensee report.

Issued on this 2 day of March 2017 (A1)

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

Original report signed by the inspector.

Ontario

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

JANET GROUX (606) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): May 26, 27, 30, 31, June 1, 2, 3, 6, 7, 8, 9, 10, 13, 14, 15, 16, 17, 20, 22, 23, 24, 2016.

The following three complaints were inspected concurrently with the Resident Quality Inspection (RQI):

a report of allegation of improper care of resident; an allegation of wrongful discharge of resident from the home, and an allegation of staff to resident abuse;

The following Critical Incidents (CI) were inspected concurrently with the RQI:

resident falls (2); allegations of resident to resident abuse (5); and resident to resident responsive behaviours (3).

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Nurse Manager (NM), Office Manager, Staff Educator (SE), Registered Dietician (RD), Dietary Manager (DM), Dietary Aide (DA), Physiotherapy Assistant (PTA), Resident Assessment Instrument Minimum Data Set (RAI-MDS) Coordinator, Support Services Manager, Food Service Workers (FSW) Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Housekeeping, Residents, and Substitute Decision Makers (SDM).

During the course of the inspection, the inspectors conducted observations of residents and home areas, medication administration, meal service delivery, infection control prevention and practices, reviewed clinical health records, staffing schedules/assignments, minutes of Residents' Council and Family Council meetings, minutes of relevant committee meetings, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Admission and Discharge

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Skin and Wound Care

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

14 WN(s)
13 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect residents from emotional abuse by anyone.

The applicable definition of emotional abuse in O. Reg. 79/10 of the Long-Term Care Homes Act, means (a) any threatening, insulting, intimidating gestures, actions, behaviour or remarks including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by someone other than a resident, or (b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

Review of an identified CI in 2015, reported an allegation of resident to resident abuse.
Review of resident #050 and #051's progress notes indicated the two residents spent time with each other several times during the day on a daily basis. Further record review and staff interviews revealed resident #050 and #051 visits with each other were not supervised by staff.

Review of resident #051's plan of care indicated resident was diagnosed with a medical condition and directed staff to monitor him/her for signs of agitation and ensure the resident was separated from resident #050 as needed when he/she was observed to be agitated.

Interview with PSW #145 revealed resident #050 had been observed to be aggressive towards resident #051 during past visits before the incident on an identified date. The PSW revealed resident #050 had been observed to be demanding towards resident #051and would get upset when resident #051 refused his/her demands. PSW #145 further revealed resident #051 would become agitated when resident #050 became demanding and would become physically aggressive towards resident #050 and get away from resident #050. PSW #145

stated an identified staff member informed him/her that afternoon on an identified date that he/she heard a disturbance in resident #050's room. The PSW stated he/she ran to resident #050's room and observed resident #050 and exhibiting physical aggression towards resident #051 and observed resident #051 to be agitated and screaming and was attempting to get away from resident #050.

Interview with an identified staff member indicated he/she was near resident #050's room the afternoon of an identified date when he/she heard a disturbance coming from resident #050's room and became concerned and went over to see what was going on. The staff member revealed when he/she went over to the area of the disturbance and witnessed resident #050 exhibiting physical aggression towards resident #051. He/she directed resident #050 to stop and the staff immediately ran to get PSW #145 to assist.

The inspector was not able to interview resident #051 due to his/her medical condition.

Interview with resident #050 revealed he/she and resident #051 were quarrelling on the identified date and further revealed they have had quarrels with each other prior to this incident. He/she indicated he/she was not aware resident #051's medical diagnoses and did not know that resident #051 was cognitively impaired.

Interview with the SDM revealed he/she was aware that resident #050 was aware of resident #051's medical condition but was having a difficult time accepting it. He/she indicated the home did not communicate that they had concerns with resident #050 and #051 visiting each other prior to the incident on the identified date.

Interview with the DOC revealed there had been incidents between resident #050 and #051 but not as serious as the incident on the identified date. He/she further revealed the SDM had informed the home that resident #050 had a strong personality and liked to be in control, can be frightening and can get physical. He/she stated staff had reported concerns with resident #050 and #051's behaviours towards each other. He/she indicated the home had communicated their concerns to the SDM and confirmed that visits continued until the incident on the identified date.

2. The licensee has failed to protect residents from emotional abuse by anyone.

The applicable definition of verbal abuse in O. Reg. 79/10 of the Long-Term Care Homes Act, mean (a) any form of verbal communication of a threatening or intimidating nature of any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Review of an identified CI from 2015, reported an allegation of staff to resident verbal abuse. The CI identified PSW #106 reporting inappropriate comments made by PSW #148 to resident #030.

Interview with resident #030 revealed he/she recalled the incident with PSW #148 who had made an inappropriate comment to him/her when resident #030 requested assistance with his/her care. When asked by the inspector how the comment made him/her feel the resident responded he/she felt bad and had requested another staff member to assist him/her.

Interview with PSW #106 revealed he/she witnessed PSW #148 refuse to provide assistance when resident #030 requested assistance with his/her care and made an inappropriate comment to resident #030 before walking out of resident #030's room. PSW #106 reported his/her concern to RPN #149. He/she confirmed he/she considered the incident as verbal abuse and neglect.

An interview with RPN #149 confirmed awareness of PSW #148's statement to be inappropriate when resident #030 requested assistance. RPN #149 identified the statement to be staff to resident verbal and emotional abuse.

An order has been issued based on the severity of harm is minimal harm/risk or potential for actual harm/risk and the scope was isolated. A review of the home's compliance history revealed a VPC was issued for s.19 (1) during inspection #2014_298557_0024 on December 22, 2014. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: 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.

During the RQI the following complaint was inspected in respect to resident #016. The complainant indicated that a staff member provided inappropriate care to resident #030 during a medication administration which caused the resident to become upset.

Interview with RPN #140 confirmed resident #016 required to be administered an identified medication due to his/her medical condition. He/she revealed another staff member had sustained injury while administering this medication to resident #016 in the past. He/she indicated he/she provided care in a manner to manage resident #016's responsive behaviours to avoid getting injured. Upon reflection RPN #140 confirmed he/she should have approached this differently.

Interview with RPN #124 confirmed the resident's plan of care is to have two staff present during medication administration due to resident #016's responsive behaviours. RPN #124 was aware of this incident as RPN #140 told him/her about

the incident. When asked by the inspector, RPN #140 indicated the care provided to resident #016 was not dignified and respectful.

Interview with the DOC confirmed that the way RPN #140 administered medication to resident #016 was not dignified or respectful. [s. 3. (1) 1.]

2. Review of an identified CI in 2016, reported an allegation of staff to resident verbal abuse.

Interview with PSW #139 confirmed the incident occurred during the day shift and described staff #148 pointing at the resident's head and addressed the resident in an inappropriate tone of voice about his/her care needs. PSW #139 stated he/she was surprised at how PSW#148 belittled resident #027 in the hallway in front of other staff.

Interview with PSW#106, who was present confirmed the incident and revealed that PSW#148 stated he/she had made the comment about resident #027 because of his/her care needs. PSW#106 revealed that resident #027 was upset based on observing his/her demeanour. He/she identified the comment as abuse.

Interview with resident #027 confirmed the statement made by staff #148. The resident responded that the comment did not bother him/her much because people have the right to say what they want to and indicated he/she did not require the care staff #148 indicated he/she required.

Interview with staff #148 revealed he/she did not care to discuss anything with regards to the home.

Interview with the DOC identified that the comments made by staff #148 to resident #027 were demeaning in nature. The resident was not treated with courtesy and respect. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents were fully respected and promoted: 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

Review of a Minimum Data Set (MDS) assessment on an identified date indicated resident #001 as having difficulty with his/her communication related to being understood and understanding others related to his/her medical diagnoses.

Interview with resident #001 revealed that he/she was unable to respond to the inspector's questions.

Interview with RPN #111, when asked how resident #001 expressed his/her needs, the RPN revealed that staff observe the resident for behaviours. He/she said as an example, resident #001 would become anxious when he/she needed to receive an identified care. RPN #111 revealed that resident #001 was not always able to express his/her needs.

Interview with PSW #110 revealed resident #001 could express his/her needs, but that staff also identified a particular behaviour in the resident when he/she received an identified type of care. PSW #110 further identified resident #001 did not verbally express his/herself but revealed he/she may cry when seeking his/her home and relatives.

Interview with PSW #109 confirmed that staff would often observe resident #001 for behaviours which suggested the resident wanted staff to provide an identified care. PSW #109 stated that when resident was observed starting to self-propel his/her wheelchair, it meant he/she is requesting staff to provide the identified care. The PSW revealed the resident does not typically understand others communication, but may verbalize with "yes" or "no" answer when asked whether he/she is hungry.

Interview with the ADOC revealed that resident #001 only communicates when he/she needs staff to provide an identified care.

He/she confirmed that resident #001's written plan of care did not include resident's communication abilities and strategies to meet resident #001's compromised communication and verbal skills. [s. 6. (1) (a)]

2. The licensee has failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

On June 2 and 3, 2016, the inspector observed resident #011 lying in bed in a position that was not therapeutic based on his/her medical condition and interventions according to the plan of care was not provided.

Record review of the plan of care for resident #011 revealed he/she had impaired skin integrity on identified areas of his/her body and directed staff to provide specific interventions to manage them.

Review of resident #011's kardex did not identify any interventions to manage the resident's impaired skin integrity.

Review of the physician's orders and treatment administration record (TAR) directed staff to provide intervention to address resident #011's impaired skin integrity and it was scheduled to be initiated in the morning and at bedtime and when the resident was in bed.

Interviews with PSWs #113 and #122 confirmed they had reviewed the kardex as it is in the point of care (POC). They indicated the plan of care is available in hard copy but they do not look at it. When the kardex was reviewed, both PSWs confirmed there was no direction on how to work with resident #011 with regards to his/her impaired skin integrity in regards to the interventions, however, they had knowledge of both.

Interviews with RPN #112 and #115 and ADOC #108 confirmed the written plan of care for resident #011 does not provide clear directions to the direct care providers. [s. 6. (1) (c)]

3. Record review of an MDS assessment on an identified date indicated resident #001 was frequently incontinent. Review of the written plan of care identified the resident's need for limited to extensive staff assistance during the toileting process and staff are required to ask resident #001 if he/she needs to use the toilet.

Interview with resident #001 revealed he/she was unable to respond to the inspector's general questions and to his/her need to be toileted or use the

washroom at that time.

Interview with PSW #109 revealed the resident would sometimes ask to go to the bathroom but staff observe if resident #001 exhibited a particular behaviour as an indicator to be toileted. PSW #109 further identified they have a toileting routine for resident #001. PSW #109 confirmed the plan of care did not set out clear direction on resident #001's toileting needs.

Interview with PSW #110 identified that resident #001 was sometimes incontinent and resident #001 would ask to go to the bathroom. PSW #110 indicated they would usually follow a toileting routine for resident #001. PSW #110 confirmed a toileting routine was not identified in the resident's written plan of care.

Interview with RPN#111 identified resident #001 was not incontinent very often and staff would both toilet the resident when he/she would ask and follow a toileting routine. He/she identified that resident #001 would express his/her need to be toileted or exhibit behaviours which demonstrated his/her need to be toileted.

Interview with the ADOC confirmed resident would typically exhibit behaviours which staff would observe to determine residents need to toilet and that resident #001 would verbalize his/her need to be toileted. He/she confirmed the care plan for resident #001 did not set out clear direction around resident #001's toileting needs for direct care staff. [s. 6. (1) (c)]

4. Record review of resident #003's plan of care identified the resident to be at risk due his/her medical condition. an identified condition related to his/her medical condition.

Interventions identified in the written care plan directed staff to provide two identified dietary interventions daily. The servery diet list for reference by FSWs, directed staff to provide one of the interventions at breakfast. Another list compiled by the FSS, also available for reference by FSWs indicated this intervention was to be provided as needed (PRN).

On June 2 and 3, 2016, the inspector observed the dietary interventions were not provided to resident #003.

Interview with resident #003 identified that he/she does not like one of the identified interventions and therefore would not take it. Resident #003 further stated the

intervention listed on the servery list was not provided regularly but would drink it if it were provided.

Interview with FSW #155 revealed resident #003 confirmed resident #003's was to receive the aforementioned intervention PRN as directed by nursing staff. He/she further revealed resident #003 was not provided the second intervention as he/she does not take it.

Interview with the RD confirmed that according to resident #003's written plan of care the resident was to receive two dietary interventions daily. The RD recalled when the identified intervention was changed from daily to PRN but the care plan had not been revised with this change.

Interview with the RD confirmed the plan of care did not set out clear directions to staff and others who provide direct care to the resident regarding resident #003's nutrition interventions to manage the resident's medical condition. [s. 6. (1) (c)]

5. Review of residents #003's plan of care identified a physician order for an identified diet type. Progress notes by the RD identified the order for this diet type was related to the resident's medical condition. Further record review identified a servery diet list whereby resident #003 was to receive the identified diet type with specific food restrictions.

On June 2, 2016, resident #003 was observed at lunch meal being offered and selecting a food item that was a specific food restriction.

Interview with resident #003 revealed he/she was aware of the NAS intervention to manage his/her medical condition but revealed during the interview that staff did not follow the restriction closely as he/she had been served and consumed two identified food items that were restricted to him/her.

Interview with the RD confirmed the restricted food items should not have been served to resident #003. He/she indicated that he/she had verbally informed the FSWs on the foods to avoid for implementation of resident #003's diet type intervention.

Interview with FSW #155 confirmed resident #003 was served a restricted meal item at lunch and identified there was a lack of clear written direction related to what should or should not be served, and appropriate substitutions for restricted

foods. [s. 6. (1) (c)]

6. Review of an identified CI in 2015 reported resident #013 had an unwitnessed fall and was sent to the hospital and diagnosed with an injury as a result of the fall.

Record review of the plan of care for resident #013 directed staff to offer a falls prevention device to the resident during care and if resident becomes anxious not to proceed with applying the device. This intervention was initiated on an identified date in 2014 and revised on an identified date in 2015. The kardex did not include this intervention.

Interview with PSW #134 confirmed the resident had a falls prevention device in his/ her room. The staff stated the care plan indicated to apply this device and the kardex did not direct staff to use the device. PSW #134 further stated the direction is not clear.

Interview with RN #135 and the ADOC confirmed the plan of care for resident #013 does not provide clear directions to staff that provide care to resident #013 in regards to the use of the falls management device. [s. 6. (1) (c)]

7. The licensee failed to ensure the plan of care was based on an assessment of the resident and the resident's need and preference.

Record review of resident #003's plan of care identified the resident had an identified condition related to his/her medical condition.

Interview with the RD and the NM confirmed a specific dietary food item was required and in place to nutritionally manage resident's medical condition since an identified date.

On June 2 and 3, 2016, the inspector made observations of resident #003's breakfast meal tray. It was observed that the dietary intervention was not provided to the resident.

Interview with resident #003 identified that he/she did not like the food item being provided to him/her and had not had it for years.

An interview with the RD revealed he/she was unaware of resident #003's preference change and dislike for an identified food item and the plan of care was

not based on the resident's preferences. [s. 6. (2)]

8. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

On June 2 and 3, 2016, the inspector observed resident #011 lying in bed in a position that was not therapeutic based on his/her medical condition and interventions according to the plan of care was not provided. The inspector observed an intervention was not provided to the resident.

Record review of the plan of care for resident #011 revealed he/she had impaired skin integrity on identified areas of his/her body and directed staff to provide specific interventions to manage them.

Interview with PSW #110 indicated he/she was going to provide the intervention to resident #011 but was not able to find the items required to initiate it and he/she did not have any other explanation.

Interview with RPN #112 confirmed that the PSWs are responsible to ensure the interventions are provided to resident #011 and the RPN signs the TAR. When asked does he/she not check to see if the directions are followed before signing the TAR he/she replied the PSWs are responsible to initiate this intervention.

Interview with the ADOC confirmed the care set out in the plan of care was not provided to resident #011 as specified in the plan. [s. 6. (7)]

9. Review of resident #003's written plan of care and physician's orders identified resident #003's need for an identified diet with a list of specific food restrictions to management his/her medical condition.

Observations at lunch on June 2, 2016, revealed resident #003 was offered and consumed a restricted food item.

Interview with FSW #155 confirmed resident was served a restricted food item.

Interview with the RD confirmed resident #003 should not have been offered and served a restricted food item as required by the nutrition interventions to manage his/her medical condition. [s. 6. (7)]

10. Review of resident #012's plan of care identified he/she was at high nutritional risk related to low body weight and body mass index (BMI), ongoing weight loss and decreased meal intake. Resident #012's plan of care identified he/she was to be provided a morning snack due to his/her change in condition.

Review of the nourishment menu identified the AM snack consisted of a muffin and a drink.

On June 2 and 6, 2016, resident #012 was observed being served a half a muffin and a drink. Resident consumed 100% of what was offered.

Interviews with the RD and NM confirmed a full muffin portion and drink was to be served to resident #012 and with only half a muffin offered the plan of care was not followed. [s. 6. (7)]

11. The licensee has failed to ensure that the following were documented: the provision of the care set out in the plan of care.

On June 2, 2016, the inspector observed resident #011 lying in bed in a position that was not therapeutic based on his/her medical condition and interventions according to the plan of care was not provided. The inspector observed an intervention was not provided to the resident.

Review of resident #011's treatment administration record (TAR) on an identified date, revealed RPN #112 had signed the TAR's for resident #011 as receiving the interventions.

An interview with the resident confirmed he/she did not receive the intervention. PSW #110 and RPN #112 also confirmed the same.

An interview with RPN #112 and ADOC #108 confirmed the provision of the care, as set out in the plan of care was not documented accurately. [s. 6. (9) 1.]

12. The licensee has failed to ensure if the resident was being reassessed and the plan of care was being revised because care set out in the plan has not been effective and that different approaches have been considered in the revision of the plan of care.

Resident #012 was identified during stage one of the RQI with a low BMI and no

plan.

Record review of resident #012's plan of care on an identified date indicated resident at high nutritional risk with a low BMI and a specified goal weight range (GWR) to promote weight gain.

Observations made by the inspector on June 2 and 6, 2016, noted resident #012 was absent from breakfast and offered half a muffin and beverage at morning snack. Resident #012 was also observed absent on June 2, 2016, for lunch and was offered a late tray.

Interviews with PSWs #113 and #150 revealed that resident #012 often missed breakfast for personal reasons, and would be offered a morning snack. Staff member #150 identified resident #012 eats better by his/herself so they offer resident a meal after the main dining room service. PSW #150 further identified that resident eats fairly well if he/she likes the food. PSW #113 identified that resident #012 had responsive behaviours and some days, staff need to make choices for him/her. Staff #113 stated they always make sure he/she had his/her preferred beverage choices.

A review of the Weight Summary report in PCC (point click care) identified a weight loss trend between two identified periods.

Review of resident #012's plan of care revealed a progress note reassessment by the RD on an identified date. The reassessment identified resident #012 had been refusing meals since an identified date was consuming 50-100% of two daily meals and his/her fluid intake had been dropping daily.

Resident #012 identified GWR weight had not been achieved at the time of the reassessment on an identified date. There was no assessment of alternatives approaches considered and resident #012 continued to lose weight.

Interview with the RD revealed that resident #012's GWR may not have been realistic for the resident. RD further confirmed alternative interventions were not considered in the reassessment of resident #012's nutritional status on an identified date, when the resident lost further weight and his/her goal weight range was not achieved. [s. 6. (11) (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 to ensure that there is
-a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident,
-to ensure the plan of care was based on an assessment of the resident and the residents
need and preference,
-that the care set out in the plan of care is provided to the resident as specified in the plan,
- that the provision of the care set out in the plan of care is documented,
-that if the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, that different approaches been considered in the revision of the plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Review of an identified home's policy indicated the following suggested treatment protocols for a specific identified impaired skin integrity: Reposition every two hours, resident not to stay in bed/chair for prolonged periods of time, skin to be kept dry, protect skin, care staff to report changes, send an identified type of referral, protect intact skin, cleanse area with normal saline unless something else was ordered by the doctor or suggested by the wound care coach. The policy further stated that the identified treatment protocols will be care planned.

Review of the written plan of care and TAR's did not indicate the resident had impaired skin integrity on an identified area of his/her body nor were there goals, interventions or a treatment plan identified.

Interviews with RPN #017 and the the ADOC confirmed the home did not follow the policy in regards to impaired skin integrity. [s. 8. (1) (b)]

2. Review of an identified home's policy indicated registered staff or health care aides are to check the call system every shift to ensure the call bell has not been disconnected and is operational, reports non-functional bells to the maintenance department for immediate repairs and to document checks of the call system on the daily care record (which is now in point of care (POC)).

The inspector observed on June 2 and 7, 2016, resident #002's bathroom call bell would not alarm and the pull string would disconnect from the main call system. On June 8, 2016, the inspector, PSW #129, RPN #112 and the maintenance worker #128 observed the same issues and that the call system in the bathroom was not functional.

Review of resident's #002's POC's Follow Up Question home's report revealed PSW #130 documented the following: call bell within reach of resident and did not document call bell is not operable and reported to supervisor.

Interview with the ADOC confirmed the home did not follow the policy in regards to nurse call system. [s. 8. (1) (b)]

3. The inspector observed on June 2 and 7, 2016, resident #004 bathroom call bell would not alarm and the pull string would disconnect from the main call system. On

June 8, 2016, the inspector, PSW #122, RPN #126 and the Office Manager observed the same issues and that the call system in the bathroom was not functional.

Review of an identified home's report regarding resident #004's revealed PSW #122 documented the following: call bell within reach of resident and did not document call bell is not operable and reported to supervisor.

Interview with the ADOC confirmed the home did not follow the policy in regards to nurse call system. [s. 8. (1) (b)]

4. Review of the home's policy in the Medical Pharmacies, Pharmacy Policy, and Procedure Manual for LTC Homes, section "6 Monitored Medications", policy number "6-6", subject "Shift Change Monitored Drug Count", dated January 2014, directed registered staff to count daily at shift change the monitored medications.

On June 3, 2016, while reviewing the controlled substances and narcotics, the inspector noted that the "Shift Change and Narcotic Count Record" on May 30, 2016, at 1430 hrs the registered staff leaving the shift, did not sign the record as having counted the controlled substances and narcotics with the registered staff starting the shift.

Interview with the ADOC confirmed RPN #115 did not comply with the home's policy and sign the Shift Change and Narcotic Count Record" at the end of his/her shift as directed by the home's policy.

Review of the home's policy in the Resident Care Manual "Drug Administration/Utilization", document number "01-13-24", subject "Narcotics and Controlled Drugs", dated January 2011, identified following the administration of a narcotic the registered staff will document the administration of the narcotic in the EMAR and on the "Monitored Medication Record for 7-Day Card" record.

On June 3, 2016, the inspector observed while reviewing the controlled substances and narcotics, resident #019's identified medication blister pack card contained an identified number of capsules and did not match the monitored medication record for the 7-day card.

Review of the plan of care for resident #019 revealed in the physician orders the resident was to receive an identified number of the identified medication every

morning. Review of the EMAR confirmed the resident received his/her medication.

Interview with RPN #115 confirmed he/she administered the identified medication to resident #019 but had forgotten to sign the Monitored Medication Record for Seven Day Card Record as administering the medication that morning.

Interview with The ADOC confirmed RPN #115 did not comply with the home's policy for Monitored Medication Record for Seven Day Card and sign the said record at the time of administering the Morphine to resident #019. [s. 8. (1) (b)]

5. Review of a home's policy in the Resident Care Manual, section "Activities of Daily Living", policy reference number "05-02-07", subject "Weight Change Program", version date November 2013, identified the program is to record the residents height upon admission and annually thereafter.

Review of resident #001, #005 and #023's plan of care revealed the identified residents did not have their heights taken annually.

Interview with the DOC confirmed the home did not follow the policy in regards to the measuring the height of the identified residents and it should have been done on an annual basis. [s. 8. (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 to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #5: 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. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily accessed and used by residents, staff and visitors at all times.

Each resident bathroom contains a call system. The call system has three parts: the call plate that is attached to the wall, this plate contains the cancel button when call is answered, a clear plastic pull string with a green male plug and then a green pull string with a female adaptor. The male and female adaptor joins together and or pulls apart.

On May 27, June 2, 3, and 8, 2016, the inspector tested the call bell system in resident #002's bathroom. The inspector observed the two call bell strings would separate from the green adaptor when pulled and the call system would not activate.

Resident #002 stated that the call bell separates and does not ring for him/her on occasion and that the issue been like that for a long time.

On June 8, 2016, the inspector, PSW #129, and RPN #112 and maintenance worker #128, checked the call system in the resident's bathroom. The call bell strings separated and the call system did not activate.

Interview with the OM confirmed he/she was not aware of this problem and it had not been reported. The home did not ensure that the communication system could be easily used by the resident #002. [s. 17. (1) (a)]

2. On May 26, June 2, 3 and 8, 2016, the inspector tested the call bell system in resident #004's bathroom. The inspector observed the two call bell strings would separate from the green adaptor when pulled and the call system would not activate.

On June 8, 2016, the inspector, PSW #122, and RPN #126 checked the call system in the resident's bathroom. The call bell strings separated and the call system did not activate.

Interview with the OM confirmed he/she was not aware of this problem and it had not been reported.

The home did not ensure that the communication system could be easily used by the resident #004. [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 to ensure that the home is equipped with a resident-staff communication and response system that can be easily accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, was immediately investigated: emotional abuse of a resident by anyone.

The applicable definition of emotional abuse in O. Reg. 79/10 of the Long-Term Care Homes Act, means (a) any threatening, insulting, intimidating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or (b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks, understands and appreciates their consequences.

During the RQI the following complaint was inspected in respect to resident #016. The complainant indicated that a staff member provided inappropriate care to resident #030 during a medication administration which upset the resident.

Interview with RPN #140 confirmed the relative of resident #016 thought he/she was abusing their loved one, the RPN continued to state he/she thought they were protecting the resident and his/herself and did not see his/her actions as abusive. RPN #140 also informed the inspector that he/she submitted a letter to the DOC in regards to this incident.

Interview with RN #143 confirmed that he/she spoke with RPN #140 after it was brought to his/her attention and directed the RPN to seek assistance next time instead of providing care by him/herself. The RN further stated he/she left a voice mail for the DOC and this is the first time now the RN has heard anything about the incident.

The DOC confirmed he/she reviewed the letter from RPN #140 and felt there was no emotional abuse towards resident #016 and therefore did not do a complete investigation. [s. 23. (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 to ensure that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: emotional abuse of a resident by anyone, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident’s plan of care.

"PASD" means personal assistance services device, being a device used to assist a person with a routine activity of living.

The inspector observed during the stage one inspection on May 26, 2016, an identified PASD activated on resident #005's bed.

Review of resident #005's plan of care did not identify that the resident required the identified PASD when in bed for his/her mobility.

Interviews with PSWs #106, #125 and RPN #124 revealed the resident required the identified PASD when in bed for his/her mobility and to assist during care and this information should be in the plan of care but was not.

Interviews with RPN #124 and the ADOC confirmed resident #005's plan of care did not include that resident required a PASD for his/her mobility and confirmed that this was not identified in his/her plan of care. [s. 33. (3)]

2. The inspector observed during the stage one inspection on May 27, 2016, an identified PASD being used on resident #008's bed.

Review of resident #008's current plan of care did not identify the use of the identified PASD.

Interviews with PSW #116, #123 and RPN #124 revealed resident #008 requires the identified PASD when he/she is in bed to assist him/her with mobility, and also for his/her comfort, and security.

Interview with RPN #124 indicated resident's plan of care did not identify the resident required the use of a PASD when in bed.

Interview with the ADOC confirmed resident #008's plan of care should have identified that he/she required the use of a PASD when in bed for his/her comfort and security. [s. 33. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received 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.

Resident #010 was identified as having impaired skin integrity to an area of his/her body triggered through an MDS assessment.

Review of the plan of care for resident #010 revealed the resident had impaired skin integrity to an identified area of his/her body and a protective ointment was applied and a TAR was created. The TAR was reviewed and no entry for this treatment was found nor was a TAR created for the identified impaired skin integrity issues as indicated in the notes.

On an identified date, an entry revealed: resident has impaired skin integrity on an identified area of his/her body and protective ointment applied and resident could benefit from a prescription.

On an identified date, an entry revealed: staff report resident has a small open area, cleansed and cream applied. This entry did not identify where the open area was located.

The assessment section of resident #010's chart was reviewed and the following was found: Five "Skin-Weekly Impaired Skin Integrity Assessment" were completed for the an identified area of the resident's body and two "Skin - Weekly Impaired Skin Integrity Assessment" completed for his/her for another area of his/her body.

The home uses the following assessment: "Skin - Weekly Wound Assessement - includes Bates-Jensen" and directed for staff to use for any resident with an identified skin impairment and this assessment was not initiated for resident #010 when the resident was observed to have impaired skin integrity on an identified date.

Interviews with RPN #107 and the ADOC confirmed resident #010 did exhibit altered skin integrity to an identified area of his/her body. Resident #010 did not have an assessment of the impaired skin integrity observed initiated and or completed. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that a resident, exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Review of the progress notes for resident #010 on an identified date, indicated the resident had two identified impaired skin integrity issues located on an identified area of his/her body. Review of the "Skin - Weekly Impaired Skin Integrity Assessment" on five identified dates, included only issues with different identified area of his/her body.

There was no weekly assessment of the resident's impaired skin integrity on an identified area of his/her body.

Interviews with RPN #107 and the ADOC confirmed that resident #010's impaired skin integrity had not been assessed on a weekly basis by a registered staff member. [s. 50. (2) (b) (iv)]

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 a resident 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; and to -ensure that a resident, exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Review of an identified CI in 2015, reported a resident to resident physical altercation. The incident occurred when resident #043 returned to the common area agitated after receiving an identified personal care The report indicated resident #043 sat beside resident #042 and both resident began raising their voices at each other. Resident #043 then struck resident #042 on an identified part of his/her body and resident #042 responded by hitting resident #043 on an identified area of his/her body causing injury.

Review of resident #043's plan of care last revised on an identified date, indicated resident was identified with responsive behaviours related to his/her medical condition and can become verbally aggressive with staff and co-residents. The plan of care directed staff to invite resident to sit in the common area and chat with other residents on the unit.

Review of the home's policy entitle "Resident Care- Responsive Behaviours Program", #01-28-01", reviewed "January 2011", indicated a resident whose behaviour changes or their response to interventions change are to be reassessed regarding their behaviour and possible contributing factors using one of the assessment tools in #2. Following the re-assessment the interdisciplinary team is

to meet to review the outcome of the assessments and the care plan is to be reviewed, revised and updated accordingly. If responsive behaviour is observed, a more in depth assessment of the behaviour should be undertaken using any one or combination of the following processes/tools: Responsive behaviour Record (Appendix A); Dementia Observation Scale (DOS) (Appendix B); Cohen Mansfield Agitation Inventory (Appendix C).

Review of resident #043's progress notes indicated documentation on two identified dates indicated the resident had been more agitated and angry and his/her behaviours were beginning to escalate "more" lately. Further review of the resident's clinical records did not indicate that resident was assessed after exhibiting the responsive behaviours as indicated above.

Interviews with PSW #041 and #036 revealed when a resident is exhibiting a responsive behaviour that is not manageable and the interventions in the plan of care are no longer working, the charge nurse is informed and he/she would initiate a referral to an external behavioural support team, and the interventions in the plan of care would be reviewed.

Interview with ADOC confirmed it is the home's practice to initiate an assessment when a resident is exhibiting a responsive behaviour and review the interventions in the plan of care. [s. 53. (4) (c)]

2. Review of a CI from 2015 reported an allegation of resident to resident abuse.

Review of resident #051's current plan of care indicates resident was diagnosed with a medical condition and directed staff to monitor for signs of agitation when resident was with resident #050 and ensure time apart when needed and to monitor for acute changes in cognition and attempt to determine underlying causes.

Review of resident #051's progress notes indicated that the home observed changes in the resident's condition such as exhibiting responsive behaviours, unexplained injuries, and verbalization of resident #051 refusing to spend time with resident #050, and failed to determine the underlying causes on 15 identified dates.

Interviews with PSWs #123 and #145 and RPN #115 revealed there had been reported observations of resident #051 being agitated either before, during, and/or

after spending time with resident #050. They indicated the interventions were to monitor resident #050 and #051 and report to the charge nurse of any issues and remove resident #051 away from resident #050.

Interview with the DOC confirmed that actions were not taken such as reassessing the interventions in place for resident #051 until after the incident on an identified date which discontinued the two residents from spending time with each other. [s. 53. (4) (c)]

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, for each resident demonstrating responsive behaviours actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #10: 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. The licensee has failed to ensure the implementation of the nutrition care and hydration programs policies and procedures relating to nutrition care and dietary services and hydration.

Review of an identified home's policy directs the maintenance of comprehensive nutritional information for each resident to reference during dining and snack service.

The procedures directed the dietary services department head/designate to keep resident nutritional information current and consistent with all reference information documented in the residents plan of care.

Review of the resident service report for resident #003 failed to identify two dietary interventions according to the resident's written plan of care.

Interview with the NM confirmed the resident service report is for reference by staff

during dining service. The NM further confirmed the resident service report for resident #003 was not updated and current in accordance with the nutrition care plan and the home's policy. [s. 68. (2) (a)]

2. The licensee failed to ensure the weight monitoring system measures and records weight on admission and monthly thereafter for each resident.

Review of resident #012's plan of care including progress note and written plan of care along with an interview with the RD identified the resident at high nutritional risk related to weight loss, low BMI and variable intake.

Review of the PCC Weights Summary and The Pines Weight Entry form identified resident #012's identified month's weight was not recorded.

Interview with the full time RPN #151, whose responsibility is to enter resident weights into PCC was unable to confirm why a identified month's weight was not measured or recorded for resident #012.

Review of the home's policy entitled, "Weight Change Program", reference "#RESI-05-2-07", version "November 2013", directed registered staff to ensure the current weight of individual resident, including re-weight if applicable is recorded by the tenth day of each month either paper or electronically.

Interview with the RD and the DOC further revealed an unawareness as to why an identified month's weight was not measured and recorded for resident #012. [s. 68. (2) (e) (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 -to ensure the implementation of the nutrition care and hydration programs policies and procedures relating to nutrition care and dietary services and hydration,
-to ensure the weight monitoring system measures and records weight on admission and monthly thereafter for each resident, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: 4. Any other weight change that compromises their health status.

Resident #012 was identified in stage one related to a low BMI and no plan.

A review of the Weight Summary report in PCC identified that resident #012's weight decreased between two identified dates.

Review of resident's written plan of care on an identified date indicated resident at high nutritional risk, refusing meals at times or exhibiting behaviours during meals. Staff were to encourage resident #012 to come to the dining room, to provide a

morning snack when breakfast was not attended. The written plan of care identified resident #012 to maintain an identified body goal weight range as a goal for the resident.

On June 2, 2016, at 0822 hrs, the inspector observed resident #012 in his/ her room awake in bed and waving for the inspector to come into his/her room and to reveal to the inspector that he/she was all alone. During this time breakfast was being served in the main dining room. Later that morning the resident was observed being offered a half muffin and coffee, with PSW #113 stating we usually give half a muffin so they eat their lunch; if they are tiny eaters we don't want to spoil his/her lunch by offering a full muffin. At 1209 hrs resident #012 was observed sitting in his/her wheelchair adjacent to the dining room, then moving about the unit back into his/her room at 1250 hrs while lunch meal service was underway. PSW #155 stated resident #012 was served a late tray related to his/her behaviours. That afternoon, the inspector observed the afternoon snack pass and resident #012 was not offered an afternoon snack.

Interview with RPN #131 identified resident #012's food intake as hit or miss and since an identified date, residents behaviours had worsened. PSW #131 revealed that on occasion staff would seat resident #012 outside the dining room and hand him/her a sandwich and he/ she would eat it. PSW #131 revealed that when the resident does not attend breakfast, the staff will offer him/her a morning snack but it can be hit or miss if he/she eats it. RPN #131 further stated any weight loss would compromise resident #012's health status including the weight loss between two identified dates. The registered staff stated that a referral would be sent to the RD on an identified date related to the weight loss.

Interview with the RD confirmed resident #012 was at high nutritional risk related to an identified BMI, slow weight loss and refusing breakfast and often other meals related to responsive behaviours. It was further confirmed the weight loss obtained between two identified periods would compromise resident's health status and a referral was not received. The RD revealed the home had a Wound And Skin Care/Weight Committee whereby the interdisciplinary team met monthly to discuss residents including those with weight changes. The RD confirmed that #012's weight change was not identified or discussed at identified meetings and the system only triggers those residents with a 5%, 7.5% and 10% weight change over the time period identified for in the regulations.

Interview with RPN #151, identified that #012's weight change between identified

dates, could compromise resident #012's health status, and that weight changes are not normally assessed by RPN #151. The RPN confirmed a referral was not sent to the RD.

Interview with the DOC confirmed that the home's Wound and Skin Care/Weight committee is where weight changes are assessed using an interdisciplinary approach. It was further confirmed by the DOC and ADOC that resident #012's weight change during identified dates was not identified or assessed at the committee meeting and that the home's system to identify weight triggers does not identify other weight changes that could compromise a residents health status. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. The licensee failed to ensure an individualized menu was developed for a resident when whose needs cannot be met through the home's menu cycle.

Review of resident #003's plan of care identified a physician diet order on an identified date, for an identified diet intervention. A progress note, dated an identified date, by the RD confirmed the resident was placed on this diet. The resident service report, provided to FSWs, identified resident #003's diet a list of food items restricted to him/her.

A review of the home's therapeutic menus failed to identify a menu cycle for this diet order.

On June 2, 2016, the inspector observed resident #003 during lunch being offered and selecting a restricted food choice. Resident interview confirmed he/she was aware of the identified diet and intervention to manage his/her medical condition but revealed he/she had been served a restricted food choices.

An interview with the FSW #155 identified there was a lack of clear written direction related to what should or should not be served and what appropriate substitutions for high sodium menu choices. The FSW confirmed the home's therapeutic menus did not include the identified diet, with the list of the restricted food items.

Review of the home's policy entitled "Diets Available", last updated, "September 2015", stated the registered dietitian will create an individualized diet or therapeutic menu for each resident whose needs cannot be met through the standard diet types, diet textures and/or fluid consistencies.

Interview with the RD and NM confirmed an individualized diet or therapeutic menu for resident #003's diet had not been developed. [s. 71. (5)]

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 an individualized menu is developed for the resident if their needs cannot be met through the home's menu cycle, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

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

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the persons who have received training

under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

Review of the home's policy entitled, "Staff Reporting And Whistle-Blowing Protection", policy "#01-02-09", dated "September 2013" stated the following:
Staff should be aware that section 24(1) of the LTCHA requires certain persons to make immediate reports to the MOHLTC Director where there is a reasonable suspicion that certain conduct or events occurred or may occur. (Section 24(1) is set out in the Appendix to this policy and for clarification about who must report see section 105 of the LTCHA regulation, which is included in the Appendix). Staff should immediately report through this policy any conduct or events that may lead to a mandatory/immediate report under section 24(1). Staff should also understand that is an offence under the LTCHA to discourage or suppress a section 24(1) report. No Retaliation or Discouragement of Reports. The Home will protect staff members from harassment, coercion, penalty or discipline in the context of the following:
1 Reports in good faith under this policy, and
2. Disclosure of anything to an inspector or the MOHLTC Director, or giving evidence in a proceeding under the LTCHA or during a coroner’s inquest.

The Home will protect a resident (and his or her family members, SDM, and persons of importance) against any threats or discrimination in connection with the resident’s disclosure of anything to an inspector or the MOHLTC Director, or his or he giving evidence in a proceeding under the LTCHA or during a coroner’s inquest.

Staff members and board members must not do anything to discourage any of the following:
1. Reports under this policy,
2. Mandatory/immediate reports under the LTCHA, and
3. Disclosures to an inspector or the MOHLTC Director, or the giving of evidence in a proceeding under the LTCHA or during a coroner’s inquest.

A staff member who retaliates, threatens a resident, or discourages a report in breach of this policy may be subject to disciplinary action, which may include termination or removal.

Review of a home's document on an identified date, included the following statement:
As employees of The Pines you are protected by the Staff Reporting and Whistle-

Blowing Protection policy. Please find a copy of this policy in this package. In a nut shell Whistle-Blowing Protection means – "We do not shoot the messenger" – It is mandatory to report and unless an item is reported in bad faith (i.e. with bad intent based on untrue information) there will be no repercussions for the reporting of abuse. It is in fact an expectation of all employees and failure to report is subject to discipline. We are all here together to create a safe and caring home for the residents who have selected The Pines as a place to live. If anyone is witness to abuse, suspects abuse or neglect you must report it as soon as possible.

Nine staff interviews revealed an understanding that Whistle Blowing Protection against retaliation was provided by the home, The Pines, with an unawareness of Whistle Blowing Protection afforded by section 26 by the LTCHA.

Interview with the DOC confirmed that Whistle Blowing Protection afforded by section 26 of the LTCHA had not been communicated to staff. [s. 76. (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 to ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations., to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

On June 3, 2016, during the medication observation of resident #011, the inspector observed RPN #115 administer an identified medication without checking the resident's pulse.

Review of the physician order revealed the identified medication is to be administered if pulse is greater than 50 beats per minute.

As RPN #115 was signing off his/her EMAR record he/she realized that he/she did not take the residents pulse prior to the administration of the medication. The RPN immediately took the pulse.

Interview with the ADOC confirmed that RPN #115 did not administer resident #011's medication as directed by the prescriber. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

(A1)
The following Non-Compliance has been Revoked: WN #15

WN #15: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Issued on this 2 day of March 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JANET GROUX (606) - (A1)

Inspection No. / No de l'inspection : 2016_393606_0009 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 016066-16 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Mar 02, 2017;(A1)

Licensee / Titulaire de permis : THE DISTRICT OF THE MUNICIPALITY OF MUSKOKA
98 Pine Street, BRACEBRIDGE, ON, P1L-1N5

LTC Home / Foyer de SLD : THE PINES
98 PINE STREET, BRACEBRIDGE, ON, P1L-1N5

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Katheine Rannie

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To THE DISTRICT OF THE MUNICIPALITY OF MUSKOKA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall pro residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with s. 19. (1). to ensure that residents are protected from abuse by anyone and are not neglected by the licensee or staff.

1. Protect resident #051 from abuse by resident #050.
2. Re-educate and train all staff on:
a. the home's zero tolerance of abuse and neglect policy
b. identifying forms of resident to resident and staff to resident abuse and staff to resident neglect,
3. Monitor and audit staff compliance to the home's policy.

The plan should identify who will be responsible for completing all of the tasks identified in the order and the timeline in which the plan will be implemented.

The plan shall be submitted by January 31, 2017, via email to janet.groux@ontario.ca.

Grounds / Motifs :

1. The licensee has failed to protect residents from emotional abuse by anyone.

The applicable definition of emotional abuse in O.Reg. 79/10 of the Long-Term Care Homes Act, means (a) any threatening, insulting, intimidating gestures, actions, behaviour or remarks including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by someone other than a resident, or (b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

Review of an identified CI in 2015, reported an allegation of resident to resident abuse.

Review of resident #050 and #051's progress notes indicated the two residents spent time with each other several times during the day on a daily basis. Further record review and staff interviews revealed resident #050 and #051 visits with each other were not supervised by staff.

Review of resident #051's plan of care indicated resident was diagnosed with a medical condition and directed staff to monitor him/her for signs of agitation and ensure the resident was separated from resident #050 as needed when he/she was observed to be agitated.

Interview with PSW #145 revealed resident #050 had been observed to be aggressive towards resident #051 during past visits before the incident on an identified date. The PSW revealed resident #050 had been observed to be demanding towards resident #051and would get upset when resident #051 refused his/her demands. PSW #145 further revealed resident #051 would become agitated when resident #050 became demanding and would become physically aggressive towards resident #050 and get away from resident #050. PSW #145 stated an identified staff member informed him/her that afternoon on an identified date that he/she heard a disturbance in resident #050's room. The PSW stated he/she ran to resident #050's room and observed resident #050 and exhibiting physical aggression towards resident #051 and observed resident #051 to be agitated and screaming and was attempting to get away from resident #050.

Interview with an identified staff member indicated he/she was near resident #050's room the afternoon of an identified date when he/she heard a disturbance coming from resident #050's room and became concerned and went over to see what was

going on. The staff member revealed when he/she went over to the area of the disturbance and witnessed resident #050 exhibiting physical aggression towards resident #051. He/she directed resident #050 to stop and the staff immediately ran to get PSW #145 to assist.

The inspector was not able to interview resident #051 due to his/her medical condition.

Interview with resident #050 revealed he/she and resident #051 were quarrelling on the identified date and further revealed they have had quarrels with each other prior to this incident. He/she indicated he/she was not aware resident #051's medical diagnoses and did not know that resident #051 was cognitively impaired.

Interview with the SDM revealed he/she was aware that resident #050 was aware of resident #051's medical condition but was having a difficult time accepting it. He/she indicated the home did not communicate that they had concerns with resident #050 and #051 visiting each other prior to the incident on the identified date.

Interview with the DOC revealed there had been incidents between resident #050 and #051 but not as serious as the incident on the identified date. He/she further revealed the SDM had informed the home that resident #050 had a strong personality and liked to be in control, can be frightening and can get physical. He/she stated staff had reported concerns with resident #050 and #051's behaviours towards each other. He/she indicated the home had communicated their concerns to the SDM and confirmed that visits continued until the incident on the identified date.

(606)

2. 2. The licensee has failed to protect residents from emotional abuse by anyone.

The applicable definition of verbal abuse in O. Reg. 79/10 of the Long-Term Care Homes Act, mean (a) any form of verbal communication of a threatening or intimidating nature of any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Review of an identified CI from 2015, reported an allegation of staff to resident verbal abuse. The CI identified PSW #106 reporting inappropriate comments made by PSW #148 to resident #030.

Interview with resident #030 revealed he/she recalled the incident with PSW #148 who had made an inappropriate comment to him/her when resident #030 requested assistance with his/her care. When asked by the inspector how the comment made him/her feel the resident responded he/she felt bad and had requested another staff member to assist him/her.

Interview with PSW #106 revealed he/she witnessed PSW #148 refuse to provide assistance when resident #030 requested assistance with his/her care and made an inappropriate comment to resident #030 before walking out of resident #030's room. PSW #106 reported his/her concern to RPN #149. He/she confirmed he/she considered the incident as verbal abuse and neglect.

An interview with RPN #149 confirmed awareness of PSW #148's statement to be inappropriate when resident #030 requested assistance. RPN #149 identified the statement to be staff to resident verbal and emotional abuse.

An order has been issued based on the severity of harm is minimal harm/risk or potential for actual harm/risk and the scope was isolated. A review of the home's compliance history revealed a VPC was issued for s.19 (1) during inspection #2014_298557_0024 on December 22, 2014. [s. 19. (1)]
(110)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

Jan 20, 2017

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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
Toronto ON M5S 2B1
Télécopieur : 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
Toronto ON M5S 2B1
Télécopieur : 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 2 day of March 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JANET GROUX - (A1)

Service Area Office /
Bureau régional de services : Toronto