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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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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
Feb 04, 2016;	2015_391603_0029 (A1)	021579-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE CITY OF GREATER SUDBURY
200 Brady Street PO Box 5000 Stn A SUDBURY ON P3A 5P3

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

PIONEER MANOR
960 NOTRE DAME AVENUE SUDBURY ON P3A 2T4

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

MARIE LAFRAMBOISE (628) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The Licensee requested an extension to the compliance date for Compliance Order #007 from February 5, 2016 to April 15, 2016.

Issued on this 4 day of February 2016 (A1)

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

Original report signed by the inspector.

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

MARIE LAFRAMBOISE (628) - (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): September 21-25 and September 28-October 2, 2015.

During the course of the inspection, the inspectors reviewed residents' health care records, reviewed various policies, procedures, and programs, conducted a daily walk-through of the home, observed the delivery of resident care and staff to resident interactions, and observed medication administration. The following logs related to the Ministry of Health and Long-Term Care were also completed during the inspection: 8 Critical Incident Reports and 1 Complaint report.

During the course of the inspection, the inspector(s) spoke with Administrator, Manager of Resident Care, Manager of Therapeutic Services, Manager of Food Services, Manager of Administration, Manager of Physical Services, Program and Service Coordinators, Housekeeping Coordinator, Food Services Supervisors, RAI-MDS Staff, Registered Staff (RNs and RPNs), Occupational Therapists, Behavioral Support Ontario Staff, Activity Worker, Personal Support Workers (PSWs), Nutritional Staff, Housekeeping Staff, Residents, and Family Members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Critical Incident Response

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

Training and Orientation

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

18 WN(s)
9 VPC(s)
9 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 ensure that residents were protected from abuse by resident #019.

Inspector #612 reviewed a Critical Incident (CI) Report which was reported to the

Director. The report described resident to resident abuse. Resident #019 was being monitored by Behavioral Support Ontario (BSO) and had close monitoring by staff in place due to a previous incident with another resident. On a certain date, resident #020 and resident #019 wandered into another resident's room and an altercation took place. Staff overheard resident #020 yelling and the staff entered the room to find resident #020 pushing a chair, towards resident #019. Resident #019 then struck resident #020 in the face. Registered staff intervened and resident #019 and #020 were separated. Resident #020 sustained an injury but did not require a visit to the hospital.

Inspector reviewed the home's investigation notes which indicated that PSW #158 who was providing close monitoring, had turned away from resident #019 as two other residents were becoming verbally aggressive. When PSW #158 turned their back to attend to another resident, resident #019 had left. When PSW #158 discovered that resident #019 was gone, they went to look for the resident.

Inspector reviewed resident #019's health care record. Resident #019 was admitted to the home and transferred to a specific unit, due to their behaviours. The home's internal BSO staff became involved with the resident at the time of admission, however, the resident was discharged from their services, as the resident was adjusting well on the specific unit.

On a certain date, resident #019 displayed behaviours towards resident #029 and on another date, resident #019 displayed behaviours towards resident #030's family member. Inspector confirmed with Program Coordinator #152 that no referrals, assessments, or updates to resident #019's care plan were completed to reflect resident #019's behaviours.

On a certain date, two other incidents of behaviours by resident #019 occurred towards resident #031 and #032 who were not injured and no Critical Incident Report was reported to the Director. Inspector noted that an internal BSO referral was completed after the two behaviour incidents.

On 2 specific dates, it was documented in the progress notes that resident was displaying behaviours towards other residents, particularly resident #030. Resident #019 was upset with resident #030's family while visiting with them and attempted to "go after" resident #030's family.

On a certain date, BSO S#129 completed their initial assessment, the care plan was

reviewed and updated to reflect certain behaviours and triggers. The care plan indicated that staff would need to be vigilant in knowing resident #019's location, especially in the evening when behaviours were not as easy to redirect. Staff were directed to monitor resident #019 around certain residents.

On a certain date, PSW #160 found resident #019's door closed. When PSW #160 tried to enter resident #019's room, they noted that resident #033's chair was blocking the door and resident #019 walked quickly into their bathroom. PSW #160 called for assistance and stayed in the room between resident #019 and resident #033. Resident #033 sustained several injuries. Resident #019 had blood on their hands and their hands were shaking. Resident #033 was sent to hospital and the police were notified of the incident. The police questioned resident #019 who remembered the incident and explained that resident #033 was acting inappropriately towards them. Resident #019 told the police officer that they did hit resident #033. DOS charting and one to one staffing was initiated to monitor resident #019. A Critical Incident Report was reported to the Director. Resident #019's medications were changed and a referral to external BSO was completed.

On a certain date, resident #019 was flagged for high risk behaviours and staff were alerted to new interventions in the care plan and in the shift report binder. The information included:
-Staff to be vigilant especially in evening to try to redirect resident away from specific residents. Reassure resident that you will care for specific residents and keep them safe.
- If other residents are awake and wandering in the unit, staff are to redirect them out of resident #019's home neighborhood.
- When redirecting resident #019 from specific residents, direct them to another task, attempt to engage them in an activity. Resident enjoys different activities.
- Code White to be called if resident displays certain behaviours.

On a certain date, PSW #161 assigned to stay with resident #019 left the unit without notifying another staff member. Resident #019 was found by RPN #163 in resident #034's room. Resident #019 displayed behaviours toward resident #034. RPN #163 intervened and separated residents immediately. No injuries were noted to resident #034. RPN #163 reinforced to PSW #161 that resident #019 was to be closely monitored at all times.

On July 22, 2015, 2 safety devices were placed on resident #019's door to notify staff when resident #019 left their room, or when other residents entered their room.

External BSO consultant assessed the resident and they felt that the current interventions were appropriate.

Inspector reviewed the resident's progress notes which identified that there were 11 incidents of abusive behaviours by resident #019 towards other residents and 9 other incidents of responsive behaviours.

Inspector observed a certain document giving instructions for staff providing close supervision to resident #019. The interventions were initiated on a certain date and revised later. This document was accessible to the assigned staff who was closely monitoring resident #019. The document also indicated that for each shift, the RPN on duty was responsible to review instructions with all staff on that unit, and that all staff needed to be aware of all responsibilities of the employee who was providing close supervision, and when they were to be replaced for breaks. The document included information such as the activities that the resident enjoyed and interventions to redirect resident when exhibiting certain behaviours. The same information could also be found in the resident's care plan.

Inspector attended and observed evening shift report on a certain date and day shift report on a certain date. During these 2 shift reports, resident #019's behaviours were not discussed and the staff did not discuss anything with the staff who was responsible to supervise resident #019. Inspector interviewed the charge RPN #134, who explained that they were not familiar with the resident and that Inspector should speak with the close monitoring staff for more information. RPN #164 stated that the close monitoring staff were responsible to read the information about the resident they were caring for and registered staff would only provide additional information if something significant had occurred.

Inspector interviewed Dietary Aid #165 who was providing close monitoring for resident #019. Dietary Aid #165 was unable to provide Inspector with information regarding resident's triggers or behaviours. Dietary Aid #165 stated that they were not provided with any information at the start of the shift to indicate what resident #019's behaviours were like or what triggers to watch for. Dietary Aid #165 did not have access to resident #019's care plan which was confirmed by Program Coordinator #152. Dietary Aid #165 explained that they were familiar with resident #019 as they were the dietary aid that usually worked in the same dining room as resident #019 dined in. Dietary Aid #165 also explained that if they observed a change in resident's behaviour, they would call for assistance.

On September 30, 2015, at 1036hrs, Inspector entered the common area of a certain unit and observed resident #019 sitting alone at a table. There were other residents including specific residents, who were walking past resident #019 and there were no staff present. At one point, RPN #164 walked into the common area and Inspector inquired about the whereabouts of the close monitoring staff. RPN #164 was not able to respond to this question. As Inspector and RPN #164 started to look for the close monitoring staff, the close monitoring staff returned to the unit and explained that they had gone down the hallway to get wash cloths to fold. During this time, resident #019 was out of Dietary Aid #165's sight and RPN #164 reinforced to Dietary Aid #165 that close monitoring staff must stay with resident at all times. [s. 19. (1)]

2. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by PSW #155.

Inspector #543 reviewed a Critical Incident (CI) Report which was reported to the Director. The CI indicated allegations of abuse and/or neglect by PSW #155 towards resident #028. According to the CI resident #028's family was visiting the resident when PSW #155 entered the room and the resident became visibly upset.

A review of PSW #155's personnel file revealed a history of allegations of resident abuse and neglect. The Inspector identified that during a period of time, there were 11 allegations of abuse or neglect against PSW #155 brought forward to management. A review of a letter addressed to PSW #155 confirmed that this staff member neglected to provide the required care to resident #028. [s. 19. (1)]

3. The licensee has failed to ensure that resident #016 was not neglected by staff.

Inspector #543 reviewed a Critical Incident (CI) Report which was reported to the Director. The CI related to allegations of abuse/neglect by staff towards resident #016. According to the CI, PSW #141 discovered resident #016 in their bed with the head and foot of their bed elevated, the resident curled up in the middle of the bed, their right leg over the bed rail, and left arm underneath them. The resident's call bell was found on the bedside table and not within the resident's reach.

A review of the home's internal incident report completed on a certain date, revealed alleged abuse/neglect. The incident description indicated that PSW #141 entered resident #016's room and could hear the resident calling out for help. The resident was discovered with the head and foot of the bed elevated causing the resident to be curled up and stuck in the middle. The resident's right leg was over the bed rail, and

their left arm was underneath them. No call bell was near the resident, it was on the bedside table. Resident #016 was very upset and stated they were afraid to die if they fell asleep. The CI report indicated that this was the second time that resident #016 had been left unsafe, and the resident had expressed to staff their anger over the situation, stating they were very angry that they had been neglected all night.

A review of resident #016's progress note on a certain date, revealed that resident #016 stated they were awake all night and afraid to sleep because they were unable to roll over. The progress note indicated that the resident had a badge but was unable to reach it to ring for assistance.

A review of the home's investigation report identified that in an interview conducted between resident #016 and the Program Coordinator, the resident stated that they felt fearful to go to sleep and not wake up. The resident indicated that they were terrified, unable to locate their badge to call for assistance, and felt that when they really required assistance, no staff were available. Resident #016 identified that they were changed during the night, and no other staff member returned until the morning shift started.

A review of resident #016's care plan indicated that the night shift staff were to check the resident at 0230hrs, if they did not need to be changed at that time, the resident was to be changed by two staff members at 0500hrs, and that resident #016 would be repositioned at least every two hours.

A review of the resident #016's health care record specifically related to turning and repositioning revealed that 14 times in a certain month and 11 times in another month, there was no documentation to support that this resident had been turned and repositioned during the night shift.

A review of the home's Resident Abuse/Neglect Policy stated that abuse may be verbal, emotional, physical, sexual and financial or take the form of neglect. In this policy neglect was defined as withholding clothing, food, fluid, aid/assistive devices/equipment, medication, communications and other health services or deliberately failing to meet a dependent resident's needs. [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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Resident Abuse/Neglect Policy was complied with.

Inspector #543 reviewed a Critical Incident (CI) Report related to alleged abuse which was reported to the Director. The CI indicated that PSW #150 was verbally abusive towards resident #017. On a certain date, the resident informed staff that on a specific date, PSW #150 threatened the resident by saying "If you hurt me, I will hurt you". The CI described that during an interview with resident #017 it was discovered that the incident occurred on a certain date and the report was filed with the Director 3 days later.

A review of the home's internal investigation revealed that in an email, RN #151 informed the Program Coordinator that two PSWs reported to them that resident #017 brought forward a concern that PSW #150 was verbally abusive to the resident while providing care. A letter addressed to PSW #150 indicated that the way they spoke to resident #017 was interpreted as threatening and unprofessional. On a certain date, in a meeting held with PSW #150 and the Program Coordinator, PSW #150 was informed that resident #017 no longer wanted to receive care from them.

A review of the home's Resident Abuse/Neglect Policy, indicated that verbal abuse is defined as any form of verbal communication of a threatening or intimidating nature. The policy noted that any employee who witnesses, or becomes aware of, or suspects

resident abuse shall report it immediately to the Registered Staff, Program Coordinator, Manager of Resident Care or Director who will conduct a thorough and confidential investigation. [s. 20. (1)]

2. The licensee has failed to ensure that the Resident Abuse/Neglect Policy was complied with.

Inspector #544 reviewed a Critical Incident (CI) Report which alleged abuse by staff toward resident #025 while being fed during a lunch meal on a certain date. Resident #025 was eating slowly and had their eyes closed. Food Supervisor #144 observed a PSW feeding resident #025 and witnessed and heard the PSW say in a loud voice, "if you are not going to eat for me, I'm going to leave and look after someone else".

Inspector reviewed the home's investigation report and PSW #127 was identified. The home determined that the incident occurred but the incident was not abusive in nature. The Program Coordinator felt that the tone of PSW #127's voice may have been interpreted by other staff, residents, and families as an angry, unprofessional, demeaning and/or uncaring tone and manner. The home determined that the incident was unsubstantiated, however, a discipline letter was given to PSW #127.

Inspector #544 reviewed the home's Resident Abuse/Neglect Policy, last revised March 19, 2013, which indicated that verbal abuse is any form of verbal communication of a threatening or intimidating nature or 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'. The policy also indicated that 'the home area Program Coordinator must notify the resident's Substitute Decision Maker (SDM) immediately upon becoming aware of an alleged, suspected or witnessed incident of abuse or neglect that causes distress to the resident that could potentially be detrimental to the resident's health or well-being'.

Inspector #544 reviewed resident #025's health care record and there was no documentation that this incident had occurred or that the SDM was notified of the allegation of abuse on a certain date. Inspector interviewed MDS Coordinator #122 and PSW #125 who confirmed that the SDM had not been notified of the allegation. [s. 20. (1)]

3. The licensee has failed to ensure that the Resident Abuse/Neglect Policy was complied with.

On September 29, 2015, Inspector #627 reviewed a Critical Incident(CI) which alleged staff to resident abuse and was reported to the Director. The CI indicated that on a certain date, a staff member was in one specific unit's dining room when they overheard a Nutritional Aide (NA) yelling loudly at someone. They looked to see what was happening and saw the NA standing at a table yelling loudly at a resident, "Don't you ever do that to me again, or else, you people don't appreciate me". The staff member witnessed resident #022 sitting in the chair with a fearful look on their face.

Inspector reviewed the investigation report which indicated that RPN #146 who witnessed the incident reported the incident to the Food Supervisor #147, Manager of Food Services #148 and to the Program Coordinator #145, on a certain date.

Inspector interviewed Program Coordinator #145 who confirmed that they reported the incident to the Director, one day later. Program Coordinator #145 explained that since the incident occurred on Sunday, they did not get the email until Monday, when they submitted the CI to the Director.

Inspector #627 reviewed the home's policy Abuse: Resident Abuse/Neglect, last revised March 19, 2013, which indicated that 'certain persons, including staff members who witness, to make an immediate report to the MOHLTC Director where there is reasonable suspicion that the following incidents occurred or may have occurred: Abuse of a resident by anyone or neglect of a resident by the licensee or a staff that resulted in harm or a risk of harm to the resident. The staff member who witnesses any of the above incidents is to contact the MOHLTC on their own or if they wish with the assistance of their manager but do not have a choice to not report as it is an offence under the LTCHA'.

Inspector #627 interviewed the Director of Care who explained that the policy states that an incident of abuse needs to be reported immediately and that any staff member who witnesses abuse is to call the on call manager when there are no managers working, and then the manager on call will call the Action Line to report to the Director. [s. 20. (1)]

4. The licensee has failed to ensure that the Resident Abuse/Neglect Policy was complied with.

On September 29, 2015, Inspector #603 reviewed a Critical Incident (CI) Report which alleged staff to resident abuse and was reported to the Director. The CI indicated that on a certain date, resident #024 reported that a PSW had argued about the number of

personal supplies the resident could take with them on a leave. During this time the PSW allegedly struck the resident on the arm with the personal supply. The resident reported that the PSW put their foot out to protect themself, and the PSW stated the resident kicked them.

Inspector reviewed the home's investigation report and on a certain date, resident #024 reported the alleged abuse to Behavioral Support Ontario #153 who then reported this to RN #151, who then reported this to the Director of Care. On the next day, the Director of Care reported the alleged abuse to the Director.

Inspector reviewed the home's policy Abuse: Resident Abuse/Neglect, last revised March 19, 2013, which indicated that 'certain persons, including staff members who witness, to make an immediate report to the MOHLTC Director where there is a reasonable suspicion that the following incidents occurred or may have occurred: 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'. [s. 20. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff, immediately reported the suspicion and the information upon which it was based to the Director.

On September 29, 2015, Inspector #627 reviewed a Critical Incident(CI) Report which was reported to the Director. The CI indicated that on a certain date, a staff member was in a specific unit's dining room when they overheard a Nutritional Aide (NA) yelling loudly at someone. They looked to see what was happening and saw the NA standing at a table yelling loudly at a resident, "Don't you ever do that to me again, or else, you people don't appreciate me". The staff member witnessed resident #022 sitting in the chair with a fearful look on their face.

Inspector interviewed the Program Coordinator #145 who confirmed that they reported the incident to the Director on a specific date. The RPN #146 who witnessed the incident had reported the incident to the Food Supervisor #147, Manager of Food Services #148 and to the Program Coordinator #145, a day earlier. The Program Coordinator #145 explained that since the incident occurred on a Sunday, they did not get the email until the Monday, when they submitted the CI to the Director.

Inspector interviewed the Director of Care who explained that it was the home's

expectation that any incident of abuse needs to be reported immediately. The Director of Care explained that a staff member who witness abuse is to call the on call manager when there are no managers working, and then the manager on call will call the Action Line to report to the MOHLTC. [s. 24. (1)]

2. The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff, immediately reported the suspicion and the information upon which it was based to the Director.

On September 29, 2015, Inspector #603 reviewed a Critical Incident (CI) which was reported to the Director on a specific date. The CI indicated that resident #024 reported on the evening before, that a PSW had argued about the number of personal supplies the resident could take with them on a leave. During this time the PSW allegedly struck resident #024 on the arm with the personal supply. The resident reported they put their foot out to protect themself, and the PSW stated the resident kicked them.

Inspector reviewed the home's investigation report which indicated that the Behavioral Support Ontario staff #153 reported the resident's concerns to the RN #151 on a specific day, who then reported this information to the Director of Care to make the report to the Director, one day later. [s. 24. (1)]

3. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #628 reviewed a Critical Incident (CI) Report which was reported to the Director. The CI indicated that on a specific date, resident #026 reported to their family member that they did not like being in the home any longer, as they were yelled at by PSW #156 because the resident could not feed themself. The alleged incident happened on a specific date and was not reported to the Director until 3 days later. The report indicated that on a certain date, RPN #157 reported the incident to Program Coordinator #145 via email and Program Coordinator #145 did not receive the email until 3 days later, when Program Coordinator #145 reported to the Director of Care.

Inspector interviewed the Director of Care who explained that staff are expected to

report any alleged abuse immediately and in this case, RPN #157 should not have left an email and should have called either the Ministry to report or the Administrator on call. [s. 24. (1)]

4. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in risk of harm immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #612 reviewed a Critical Incident (CI) Report which was reported to the Director. The report described abuse by resident #019 towards resident #020. Resident #020 sustained an injury.

Inspector reviewed resident #019's health care records and noted 2 incidents of physical abuse on a specific day, involving resident #019 towards resident #031 and #032.

Inspector interviewed Program Coordinator #152 and requested the Critical Incident Report from the specific incidents. Program Coordinator #152 stated that since there was no physical injury to resident #031 and resident #032, the home's decision was that no Critical Incident Report would be completed. [s. 24. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy related to Skin and Wound Assessment was complied with.

Inspector #544 reviewed resident #002's health care record which indicated that the resident had a wound. This wound opened on a certain date, and was closed 13 days later. Fourteen days after the wound had closed, the same wound opened and an initial wound care assessment was conducted by the wound care nurse.

The next weekly wound care assessment was to be conducted on a certain date. Inspector reviewed resident #002's health care record which did not include documentation to support the completion of that assessment and PSW #127 and RPN #106 confirmed that this assessment was not completed.

Inspector reviewed the home's policy Skin and Wound Assessment, last revised January 15, 2014. The policy indicated: 'All residents of Pioneer Manor with skin breakdown will have their wounds assessed at least weekly by a registered staff member...and outcomes documented in the resident's chart'.

Inspector reviewed resident #002's health care record which did not include documentation to support that a head to toe assessment was completed on a certain date, which was the resident's first bath day of the week. PSW #127, RN #128 and RPN #106 confirmed that there was no assessment done.

Inspector reviewed the home's Skin Care Policy (Cross reference Skin Integrity-Preventive Assessment and Treatment), last revised May 1, 2014. The policy indicated: 'The assigned Health care Aide (HCA), is to complete a full head to toe assessment once per week and report all concerns to registered staff immediately. Assessment completed on the bath day in which the resident's linen is changed'. [s. 8.

(1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the home's policy related to Skin and Wound Assessment was complied with.

On September 23, 2015, Inspector #603 interviewed PSW #125 who was caring for resident #007. PSW #125 explained that the resident had 2 wounds. One of the wounds required a dressing change and the other wound no longer required a dressing change.

On September 23, 2015, Inspector reviewed the Wound Assessment Record Binder on a specific unit. In the binder, there were 2 identified Wound Assessment Record reports for resident #007. One report had 2 specific wounds and one of these wound assessments was due on a specific date, but was last done 7 days prior to the due date. The other wound assessment was due on a specific date but was last done one week prior. RPN #124 confirmed that the weekly wound assessments were not completed as required. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee has failed to ensure that the home's policy related to Medication Administration was complied with.

i) On September 22, 2015 at 1230hrs, Inspector #603 observed medications already pre-poured and ready to be administered, located in the medication room. Inspector observed that RPN #104 had prepared specific injections and had pre-poured, crushed, and mixed a medication tablet in pudding. RPN #104 confirmed having prepared medications in advance and explained that they were waiting for the residents to finish lunch. All medications were prepared prior to 1200hrs, when they were to be given.

On September 23, 2015, Inspector interviewed the Director of Care who explained that staff are not to pre-pour medications and once the medications are prepared, the staff need to administer the medications to the residents.

Inspector #603 reviewed the home's Medication Administration Policy, last revised May 8, 2014. The policy indicated that 'Medications are administered at the time they are prepared and medications are not to be pre-poured'.

ii) On September 21, 2015 at 1200hrs while observing the dining room services in a specific dining room, Inspector #603 observed RPN #102 leave their unlocked

medication cart in the hallway, while in the dining room. Inspector interviewed RPN #102 who explained that staff are expected to keep the medication carts locked at all times when not in attendance.

On September 22, 2015 at 1230hrs, Inspector #603 interviewed RPN #104 who explained that they had left their locked medication cart in the medication room on a specific unit. When RPN #104 unlocked the medication room's door, Inspector observed an unlocked medication cart. RPN #104 explained that they forgot to lock the medication cart after all, which is contrary to the home's policy.

On September 23, 2015 at 0815hrs, Inspector #603 observed an unlocked medication cart in a specific hallway. RPN #104 who was in charge of the medication cart was in the dining room, serving beverages to residents, and the medication cart was out of sight.

Inspector #603 reviewed the home's Medication Administration Policy, last revised May 8, 2014. The policy indicated that 'all medication carts and medication room are to be locked at all times when the registered nursing staff is not in attendance or does not have the cart within vision'.

iii) On September 21, 2015, Inspector #612 observed 2 tubes of medication in resident #008's bathroom. There was no pharmacy label on either tube. Inspector also observed another medication tube in resident #015's room. The tube had a pharmacy label on it.

During an interview with RPN #130, they explained that the home's expectation is that no medication will be left at the bedside and once medication has been administered, it will be returned to the medication nurse for appropriate storage.

On September 25, 2015, Inspector reviewed the home's policy Medication Administration, last revised on May 8, 2014. The policy indicated that 'all areas where drugs are stored shall be locked at all times, when not in use'.

iv) On September 22, 2015, Inspector #603 observed the medication administration on a specific unit during 1200-1230hrs. At 1200hrs, Inspector observed RPN #103 administer an injection to resident #018's left arm while sitting in their wheelchair, in the hallway adjacent to the unit's dining room. Inspector interviewed RPN #103, who explained that they would normally give the injection in the resident's room but because the resident was already in the dining room, they wheeled the resident away

from the dining room into the hallway, to give the injection. RPN #103 explained that it is the home's expectation to administer injections in the resident's room.

On September 23, 2015 at 0940hrs, Inspector interviewed the Director of Care who explained that it is the home's expectation that all treatments including injections, be administered in the resident's room.

On September 28, 2015 at 1130hrs, Inspector interviewed resident #018 who explained that they receive their injection in their room or in the dining room as the injections are due at meal times.

On September, 28, 2015, Inspector reviewed the home's Medication Administration Policy, last revised on May 8, 2014. Under General Guidelines, the policy indicated: 'To ensure the dignity and privacy of the resident is always maintained, eye/ear drops, inhalers, patches, g-tube or any type of injections are not to be administered in a public area, ie dining room, nursing station, lounge, etc.' [s. 8. (1) (b)]

4. The licensee has failed to ensure that the home's policy Responsive Behaviours Prevention, Assessment and Management of, was complied with.

Inspector #612 reviewed a Critical Incident (CI) Report which was reported to the Director. The CI described resident #019 being abusive towards resident #020.

Inspector noted that resident #019 displayed behaviours on three different dates. Inspector confirmed with Program Coordinator #152 that no referrals were completed for BSO involvement.

On a specific date, resident #019 displayed two more behaviours, once toward resident #031 and once toward resident #032. Resident #031 and #032 did not sustain any injury. After the two incidents, a referral was completed for BSO involvement for resident #019's behaviours.

Inspector #612 reviewed the home's policy Responsive Behaviours Prevention, Assessment and Management of, last revised December 5, 2014. The policy indicated that 'All residents who are presenting with responsive behaviours will be referred to BSO'.

Inspector interviewed the Program Coordinator #152 who explained that BSO would be referred to, in the event that any resident is displaying increased responsive

behaviours. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

Inspector #612 interviewed resident #004, #008, and #012 who stated that the home

is always short of PSWs and that they do not get their tub baths as scheduled.

Inspector reviewed resident #004, #008, #009, #012, #013, and #014's health care records. Inspector noted that during a period of time (one month), resident #004 had 5 bed baths and 3 tub baths; resident #008 had 2 bed baths and 3 tub baths; resident #009 had 2 bed baths and 5 tubs baths; resident #012 had 5 bed baths and 3 tub baths; resident #013 had 6 bed baths and 3 tub baths; and resident #014 had 3 bed baths. Inspector reviewed their care plans and noted that for all of these residents, their preference was a tub bath.

Inspector #544 interviewed the President of the Family Council who stated that insufficient staffing and tub baths not being completed, have been ongoing issues and have been discussed multiple times at Family Council meetings. The Administrator attended the meeting in June, however, members of the Council felt that these issues were still persisting, and felt that no concrete solution had been presented.

Inspector #612 interviewed PSWs #118, #127, #119, and #126 who explained that they work short almost daily on any unit. They explained that when they are short staffed, they will give bed baths instead of tub baths or showers, as there is not enough time.

Inspector #612 interviewed BSO RPN #129 who explained that for a period of 2 weeks, they were pulled from their regular duties of BSO for 2.5 of their 8 shifts to do nursing duties. During this time, the BSO work did not get done.

Inspector #612 interviewed Therapy Manager #135 who explained that the home's expected target referral time between BSO to initial contact with the resident was 24hrs, however, the wait time was much longer due to BSO staff being pulled for other nursing duties. Therapy Manager #135 explained that between January and March, 2015, the average time between initial referral to BSO and initial contact with resident was 60hrs. Between April and June, 2015, it was 67.3hrs, and between July and September, 2015, 58.46hrs.

Inspector was provided with an excel tracking document from Administration Manager #140. This document indicated that between September 1 - 27, 2015, the home was short staffed 6.7% of Personal Support Worker (PSW) shifts, 2.8% of Registered Practical Nurse (RPN) shifts, and 1.7% of Registered Nurse (RN) shifts.

Inspector interviewed the Director of Care who confirmed that the direction to the

PSWs had been that when they were short staffed on a unit, bed baths were to be completed instead of the resident's preferred method of bathing.

LTCHA, 2007 S.O. 2007, r.31.(3) was issued previously as WN and VPC during Inspection #2012_138151_0017. [s. 31. (3)]

2. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

Inspector interviewed Dietary Aid #165 who was providing close monitoring for resident #019 who had a history of certain behaviors. Staff #165 was unable to provide Inspector with the resident's triggers or behaviors as they did not have access to resident #019's care plan.

The Program Coordinator #152, confirmed that S#165 would not have access to resident's care plan, as they are a Dietary Aid and not a PSW, RPN, or RN. Staff #152 stated that registered staff are to provide S#165 with a report outlining the resident's behaviours. Staff #152 confirmed that the home usually tries to schedule the same staff who are familiar with resident #019's required care, however, due to staffing shortage, they were not able too.

On a certain date, Inspector entered the secure unit and noted that resident #019 who required close monitoring by staff, was sitting alone at a table. Inspector was unable to locate Dietary Aid #165 or any other staff. RPN #164 then entered the common area and was unable to locate Dietary Aid #165. Dietary Aid #165 later returned to the secure unit and explained that they had left resident #019 alone to find wash cloths for the resident to fold. [s. 31. (3)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions for resident #019 by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations.

Inspector #612 reviewed resident #019's health care record. Resident #019 was admitted and transferred to a specific unit due to specific behaviours. The home's internal BSO staff became involved with the resident at the time of admission however, the resident was discharged from their services, as the resident was adjusting well on the specific unit.

On a certain date, resident #019 displayed certain behaviours towards resident #029 and on a certain date, resident #019 became upset and attempted to hit resident #030's family member.

Inspector confirmed with Program Coordinator #152 that at that time, no referrals, interdisciplinary assessments, or updates to resident #019's care plan to identify interventions were completed, to reflect resident's certain behaviours.

On June 24, 2015, resident #019 displayed two more behaviours, once toward resident #031 and once toward resident #032. [s. 54. (a)]

2. The licensee has failed to ensure that the steps taken to minimize the risk of altercations and potentially harmful interactions from resident #019 were implemented.

Inspector reviewed resident #019's health care record which indicated that the resident displayed behaviours toward other residents on 2 specific days. Inspector confirmed with the Program Coordinator #152 that no referrals, interdisciplinary assessments, or updates to resident #019's care plan were completed to reflect resident's behaviours. After two behaviour incidents on a specific date, an internal BSO referral was completed and the Dementia Observation Sheet (DOS) was initiated.

On 2 specific dates, it was documented that resident #019 was displaying behaviours towards other residents, particularly resident #030. Resident #019 was upset with resident #030's family visiting with them and attempted to "go after" resident #030's family. BSO #129 completed their initial assessment, the care plan was reviewed and updated to reflect verbal and physical responsive behaviours. Included in the assessment was that staff will need to be vigilant in knowing resident #019's location, especially in the evening when behaviours are not easily redirected. It was noted that staff needed to monitor resident #019 around specific residents.

On a certain date, PSW #160 found resident #019's door closed. When PSW #160 entered resident #019's door, they observed that resident #033's chair was blocking the door and resident #019 walked quickly into their bathroom. PSW #160 called for assistance and stayed in the room between resident #019 and resident #033. Resident #033 had sustained several injuries. Resident #019 had blood on their hands and their hands were shaking. Resident #033 was sent to hospital and the police were notified.

On a certain date, resident #019 was flagged for high risk behaviours, staff were alerted to new interventions, and the information was added in the care plan and in the shift report binder.

On a certain date, PSW #161 assigned to to supervise resident #019 left the unit without notifying another staff member. Resident #019 was found by PSW #163 in resident #034's room. Resident #019 had displayed behaviours towards a resident. The registered staff reinforced that resident #019 was to have close monitoring staff present at all times.

Inspector reviewed progress notes during a certain period of 2 months. The notes described resident #019 exhibiting increasing behaviours toward other residents. The same notes described resident #019 exhibiting physically responsive behaviours.

Inspector reviewed a Critical Incident (CI) which was reported to the Director. The CI described resident to resident abuse. Resident #019 was being monitored by Behavioral Support Ontario (BSO) and with close monitoring staff, due to a previous incident with a specific resident. The close monitoring staff PSW #158 had turned their attention away from resident #019, when they turned back, they were unable to locate resident #019.

Resident #019 and resident #020 had wandered into another resident's room and an altercation took place between them. Staff overheard resident #020 yelling and entered the room to find resident #020 pushing a chair towards resident #019. Resident #019 then struck resident #020 in the face. Registered staff intervened and resident #019 and #020 were separated. Resident #020 sustained an injury.

Inspector interviewed the Program Coordinator #152 who explained that the direction provided to staff was that the close monitoring staff member was to keep resident #019 in their field of vision at all times.

On a specific date, Inspector entered a specific unit and observed resident #019 sitting alone at a table. There were other residents walking past resident #019. No staff was present. RPN #164 then walked into the common area and Inspector inquired where the close monitoring staff was, and RPN #164 was not able to explain where the close monitoring staff was. The close monitoring staff returned to the unit and explained that they had left to get wash cloths for the resident to fold. [s. 54. (b)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident had been assessed and their bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Inspector #612 reviewed resident #008, #009, and #010's health care records. All three residents used bed rails and their health care records indicated a focus for bed rails. There was no assessment related to the residents and their bed system.

Inspector interviewed RPN #104, RPN #131, and RN #137 who explained that these assessments are to be completed by Occupational Therapists. Therapist #138 confirmed that they complete residents' bed system assessments however, they were unable to locate these for resident #008, #009, and #010.

Inspector interviewed Therapy Manager #135 who explained that the home updated their policy in December, 2014, and started assessing the residents and their bed systems for all new admissions beginning January, 2015. Previously, assessments were only completed on residents and beds with therapeutic surfaces or if a problem was identified by the staff. There were only records to indicate that residents and beds were assessed if they had a therapeutic surface. Inspector noted that between January 1 and September 24, 2015, residents #008, #009, and #010 were not assessed and their bed systems were not evaluated. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of

entrapment.

Inspector #612 reviewed resident #008, #009, and #010's health care records. All three residents used bed rails and their health care records indicated a focus for bed rails. Inspector was unable to locate information which included steps taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Inspector interviewed RPN #104, RPN #131, and RN #137 who explained that the resident and bed system assessments are to be completed by Occupational Therapists. Therapist #138 confirmed that they complete bed system assessments, however, they were unable to locate these for resident #008, #009, and #010.

Inspector noted that between January 1 and September 24, 2015, resident #008, #009, and #010's bed were not assessed and steps were not taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (1) (b)]

3. The licensee has failed to ensure that where bed rails were used, other safety issues related to the use of bed rails were addressed, including height and latch reliability.

Inspector #612 reviewed resident #008, #009, and #010's health care records. All three residents used bed rails and their health care records indicated a focus for bed rails. Inspector was unable to locate a bed system assessment which included height and latch reliability.

Inspector interviewed RPN #104, RPN #131, and RN #137 who stated that the assessment related to the resident and their bed system which include height and latch reliability of bed rails, are to be completed by Occupational Therapists. Therapist #138 confirmed that they complete these assessments, however, they were unable to locate the assessments for residents #008, #009, and #010. [s. 15. (1) (c)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 007

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #010.

On September 22, 2015 at 0900hrs, Inspector #603 observed resident #010's bed with one half bed rail engaged on the right side of the bed and one half bed rail in the upper position (not engaged) on the left side of the bed. Inspector #603 interviewed resident #010 who explained that they have one bed rail engaged in order not to fall

off their bed.

On September 23, 2015, Inspector interviewed RPN #110 who explained that the resident required the right bed rail to be engaged due to specific reasons. The resident had a safety device on the left side of the bed and a bed alarm for when the resident attempted to climb out of bed.

On September 23, 2015, Inspector interviewed PSW #120 and PSW #121 who explained that resident #010 required one half rail to be engaged on the right side of the bed. On the left side, the resident required one half rail to be in the up position to assist resident while moving in bed. The bed was positioned low and there was a safety device on the left side to prevent injury. PSWs #120 and #121 explained that these interventions would be in the care plan under safety and all staff had access to the care plan on their working tablet. PSWs #120 and #121 explained that the resident's bed rails were considered PASDs and not restraints.

Inspector reviewed the resident's care plan and there was no focus for bed rails, PASD, or restraints, nor was there direction on which side of the bed, a safety device would be placed. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #007.

On September 23, 2015, Inspector #603 observed resident #007 sleeping in their bed with an air mattress on the bed. Inspector interviewed PSW #125 who explained that resident #007 had 1 wound which a dressing was required.

Inspector reviewed resident #007's care plan and there was no focus for altered skin integrity or skin and wound care. Inspector reviewed the Skin and Wound binder on the specific unit. In the binder, resident #007 had a list of current wounds which included 2 wounds. Inspector reviewed the Wound Assessment Record which referred to 2 different wounds. On the 'Scheduled MAR/TAR Events Report', there was only one focus for a wound. RPN #124 confirmed that there was discrepancy between the reports and that the resident still had only one wound. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care set out clear direction to staff and others who provide direct care to resident #002.

Inspector #612 reviewed the bathing schedule for resident #002 and noted that they

received bed baths on Sundays and tub baths on Wednesdays.

Inspector reviewed the resident's care plan which indicated that the resident received bed baths on Sundays and tub baths on Thursdays.

Inspector interviewed PSW #118 and PSW #127, and RPN #106 who confirmed that resident #002 received bed baths on Sundays and tub baths on Wednesdays. [s. 6. (1) (c)]

4. The licensee failed to ensure that the plan of care set out clear direction to staff and others who provide direct care to resident #009.

On multiple occasions during the inspection, Inspector #612 observed resident #009 with a half bed rail engaged on the right side of their bed and an assist bed rail (not engaged) on the left side of their bed.

Inspector interviewed PSW #118 and RPN #131 who were unable to explain why the resident had a half rail engaged on the right side of their bed. PSW #118 and RPN #131 stated that the resident used the assist rail on the left side and that the information would be found in the care plan.

Inspector reviewed resident #009's care plan which did not contain any focus, goals, or interventions relating to the use of bed rails.

Inspector interviewed Program Coordinator #136 who confirmed that the information related to resident #009's bed rail use should be in their care plan, however it was not. [s. 6. (1) (c)]

5. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #019.

Inspector #612 reviewed resident #019's care plan which indicated that the resident had a wound. Inspector interviewed Program Coordinator #152 who explained that the resident did not have a wound. The care plan also referred to universal precautions being in place for fall prevention including using an assistive device. However, under mobility, the care plan indicated that the resident mobilized independently without any assistive device.

On multiple occasions, Inspector observed the resident ambulating independently and

Program Coordinator #152 confirmed that resident #019 ambulated independently. [s. 6. (1) (c)]

6. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #008 as specified in the plan.

Inspector #544 reviewed resident #008's health care records which indicated that the resident had 6 falls during a specific period of time.

Inspector reviewed resident #008's care plan which had a focus for High Risk for Falls and the interventions included hourly night shift visual checks or more often to ensure safety and respond to the resident's needs. Visual checks were to be recorded.

On review of resident #008's health care record, Inspector identified no documentation that supported the night shift hourly checks for resident #008.

Inspector interviewed RPN #134, who confirmed that these checks were not done as the staff were not aware of this requirement. [s. 6. (7)]

7. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #016 as specified in the plan.

Inspector #543 reviewed documentation and identified the following in an interview conducted on a certain date, with resident #016 and Program Coordinator #136.

-the resident stated that it seems like when they really need someone, no one comes and that staff should check on them at least every 2 hours.
-the resident stated that after staff changed them they are supposed to put the badge on their right side. The resident started calling for help, and no one came until the regular staff in the morning.

Inspector reviewed the resident's care plan which indicated that the night shift staff were to check the resident at 0230hrs, if they did not need to be changed at that time, they were to be changed by 2 staff members at 0500hrs and that resident #016 would be repositioned at least every 2 hours.

Inspector reviewed the Point of Care (POC) Resident Response Rate Report regarding turning and repositioning resident #016 every 2 hours for 2 months, and identified the following:

For the first month, a total of 90 responses were entered in POC. For 13% of the time, there was no documentation to support that resident #016 was turned and positioned.

For the second month, a total of 93 responses were entered in POC. For 11% of the time, there was no documentation to support that resident #016 was turned and positioned. [s. 6. (7)]

8. The licensee has failed to ensure that resident #002's plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

Inspector #544 reviewed resident #002's health care record and noted that the resident had a wound. The wound opened and was closed 13 days later. Fourteen days after the wound was closed, a wound care assessment was conducted by the wound care registered staff and noted that the same wound had re-opened.

Inspector reviewed resident #002's care plan and noted a focus for impaired skin integrity. The target date for revision was on a specific date. There was no further revision date to capture the re-opening of the wound and the fact that the first wound was healed on a specific date.

Under interventions, the revision date was on a specific date. There was no further revision date to capture the re-opening of the wound one month later and the fact that the first wound had healed. RPN #106, PSW #127, and RN #128 confirmed that there was no further revision date to capture the re-opening of the wound and that the first wound had healed. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 008, 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #9: 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

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

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident's right to be afforded privacy in treatment and in caring for his or her personal needs was fully respected and promoted.

On September 22, 2015, Inspector #603 observed the medication administration on a

specific unit from 1200-1230hrs. At 1200hrs, Inspector observed RPN #103 administrating an injection to resident #018 in their left arm while sitting in their wheelchair, in the hallway adjacent to the unit's dining room. Inspector interviewed RPN #103, who explained that they would normally give the injection in the resident's room but because the resident was already in the dining room, they wheeled them from the dining room into the hallway to give the injection. RPN #103 explained that it is the home's expectation for injections to be administered in the resident's room.

On September 23, 2015, Inspector #603 interviewed the Director of Care who explained that it is the home's expectation that all treatments including injections are to be administered in the resident's room.

On September 28, 2015, Inspector #603 interviewed resident #018 who explained that they usually get their injection administered in their room or in the dining room, because the injection is due around meal times.

On September, 28, 2015, Inspector reviewed the home's Medication Administration Policy, last revised on May 8, 2014. Under General Guidelines, the policy indicated: 'To ensure the dignity and privacy of the resident is always maintained, eye/ear drops, inhalers, patches, g-tube or any type of injections are not to be administered in a public area ie dining room, nursing station, lounge, etc'. [s. 3. (1) 8.]

2. The licensee has failed to fully respect and promote the resident's right to have his or her personal health information kept confidential.

On September 21, 2015, while observing the dining room services in a specific unit's dining room, Inspector #603 observed RPN #102 leave their unlocked medication cart in the hallway with the computer screen opened, displaying resident personal health information. RPN #102 went into the dining room to give medications. On their return, RPN #102 explained that although, the staff is expected to "shut the computer screen when not in attendance", they are unable to do this as it would take too much time in between residents.

On September 23, 2015 at 0815hrs, Inspector observed an unlocked medication cart on a specific unit's hallway. The computer screen was opened, displaying resident personal health information. RPN #104 who was in charge of the medication cart was in the dining room serving beverages.

On September 25, 2015 at 0900hrs, while walking on a specifit unit's hallway,

Inspector #544 observed one unattended medication cart in the hallway. The medication cart had the computer screen opened, displaying resident personal health information.

On September, 28, 2015, Inspector reviewed the home's Medication Administration Policy, last revised on May 8, 2014. The policy indicated that 'during administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. In addition, privacy is maintained at all times for all resident information (eg., one MAR)'. [s. 3. (1) 11. 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 ensuring that residents' rights are fully respected and promoted, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is kept clean and sanitary.

During a tour of the home on September 21, 2015 at 1030hrs, Inspector #544 noted a strong odor of urine coming from the tub room on a specific area. The tile floor was wet with urine and the odor of urine was offensive. On September 22 and 23, 2015, Inspector observed the same tub room and again, there was urine visible on the tile flooring and the odor of urine was strong.

Inspector interviewed Coordinator #111 who explained that the tub rooms are thoroughly cleaned once a week, on Sundays. Coordinator #111 explained that the the specific unit is in the old part of the home, and the ventilation fan is often not on. Coordinator #111 and Housekeeping Aid #112 confirmed that the tub room was not clean and required cleaning more often.

On September 21, 22, and 23, 2015, Inspector observed the bathroom in a specific unit's room #127, to be in disrepair, with a strong odor of urine permeating throughout the room. The caulking around the toilet bowl was cracked and missing in some areas. Black grime was caked around the toilet bowl, the urine had seeped between the toilet bowl and the flooring, and the vinyl flooring was discolored and blackened. Coordinator #111, who was with the Inspector, confirmed these findings.

During an interview with Coordinator #111 and Housekeeping Aids #112 and #117, they confirmed that the bathrooms are to be cleaned once a day but room #127's bathroom was not cleaned. Coordinator #111, Housekeeping Aids #112 and #117 also explained that a specific area of the home which consists of 62-64 rooms and another area of the home which also consists of 62-64 rooms only have one housekeeper for an 8 hour/day. They explained that each of these home areas previously had one housekeeper, each for an 8 hour/day.

On September 21, 22, and 23, 2015, Inspector observed the bathroom on a specific unit's room #227 with a strong odor of urine. There was urine on the floor and in the toilet bowl. On those three days, there was the same crusted dry feces on the raised toilet seat. Coordinator #111 who also witnessed the dry feces on the raised toilet seat, explained that the bathroom should have been cleaned daily, yet it was not done.

Inspector #544 interviewed resident #004 who explained that the regular housekeeping staff was off for a period of time and their replacement, Housekeeping Aid was not cleaning very well.

Inspector interviewed Housekeeping Aid #115 who explained that 2 specific units

have one housekeeper to clean 46 rooms daily. In the past, each unit had one housekeeper. Coordinator #111 and Housekeeping Aids #112, #115, and #117 explained that their daily duties included mopping the resident's room floor, cleaning their bathrooms, and emptying their waste bins. They are often called away from their cleaning duties to do other duties that may arise. According to Housekeeping Aid #115, due to time constraints and workload, they are unable to get all their tasks completed on a daily basis. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On September 21 and 22, 2015, Inspector #603 observed 14 resident rooms. Out of the 14 rooms, there were 6 rooms that were identified to have areas of disrepair. In a specific room, the right lower walls were marked and the drywall was damaged. Another room, had 3 drawers on the washroom's vanity that were not closing properly and were difficult to open. The lower walls in the washroom were marked and the drywall was damaged. In another room, the walls in the room and washroom were marked and the drywall was damaged. Another room had a small dresser beside the bed and the top surface of the dresser was in disrepair where the wood was damaged and the corners were lifting. The back wall beside the resident's bed had been repaired but not painted. The right lower walls were marked and the drywall was damaged. The washroom's counter had a broken ledge. In a specific room, the right lower wall and the back wall was marked and the drywall was damaged. The lower walls in the washroom were also marked and damaged. In another specific room, the right lower wall was marked and the drywall was damaged. In the washroom, there were 2 walls that were heavily marked and the drywall was severely damaged. In 2 different hallways, there were parts of the baseboards that were hanging off the wall. On September 29, 2015, Inspector #603 observed the same rooms in the same disrepair.

On September 28, 2015 at 1435hrs, Inspector #603 interviewed Manager #142 who explained that the home does not have a formal inspection program for maintenance issues except for painting. The maintenance department relies on the front line staff to bring issues forward by writing a work order. The home does have a pre-scheduled painting audit and all areas are attended to approximately every 14 months. The maintenance staff does not record the work done around these audits but will document the work done around maintenance issues.

On September 29, 2015, Inspector reviewed the home's policy on Physical Services

Policies and Procedures, last revised November 2013. The policy indicated that 'the purpose is to ensure that all exterior and interior spaces including resident rooms, hallways, stairwells and common areas are well and regularly maintained and in good repair. Procedure: 1. There is a preventive maintenance/standing work request for "home area painting", 2. The Physical Services/maintenance staff assigned to the painting assignment will audit the home area and will paint or patch as required. 3. All necessary paint assignments are to be completed within one week. 4. Completed and detailed information on the task to be signed off on WorxHub by Physical Services Staff'. [s. 15. (2) (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 ensuring that the home is kept clean and sanitary and in a good state of repair, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Inspector #612 interviewed residents #004, #008, and #012 who stated that the home is always short of PSWs and that they do not get their tub baths as scheduled.

Inspector reviewed resident #004, #008, #009, #012, #013, and #014's health care records. Inspector noted that between a period of one month, resident #004 had 5 bed baths and 3 tub baths; resident #008 had 2 bed baths and 3 tub baths; resident #009 had 2 bed baths and 5 tubs baths; resident #012 had 5 bed baths and 3 tub baths; resident #013 had 6 bed baths and 3 tub baths; and resident #014 had 3 bed baths. Inspector reviewed their care plans and noted that for all of these residents, their preference was a tub bath.

Inspector interviewed the Director of Care who confirmed that the direction to the PSWs has been that when they are short staffed on a unit, bed baths are to be completed instead of the resident's preferred method of bathing. [s. 33. (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 ensuring that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home had his or her personal items labelled within 48hours of admission and of acquiring, in the case of new items.

On Sept 21, 2015, Inspector #612 conducted a tour of the home and observed multiple personal hygiene items that were used, and not labelled in the different tub rooms and throughout the home. These items included razors, nail clippers, shaving cream, shampoo and conditioner bottles, and body wash bottles.

Inspector spoke with RPN #131 who confirmed that all residents' personal care products are to be labelled with the resident's name, and the home's expectation is that there will be no personal care products left in the tub rooms. [s. 37. (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 ensuring that each resident of the home has his or her personal items labelled within 48 hours of admission and of acquiring, in the the case of new items, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff were advised at the beginning of every shift of resident #019's behaviors, including responsive behaviors which required heightened monitoring because those behaviors posed a potential risk to the resident or others.

Inspector #612 reviewed a Critical Incident (CI) Report which was reported to the Director. The report described resident to resident abuse. According to resident #019's health care record, the resident displayed behaviours on many occasions and required close supervision.

Inspector #612 attended and observed an evening shift report and a day shift report. During these shift reports, resident #019's behaviours were not discussed and the staff did not discuss the resident's behaviours with the staff who was responsible to supervise resident #019 on those shifts.

Inspector interviewed RPN #164 who explained that the staff do not review resident #019's behaviours at each shift report. Inspector interviewed RPN #134 who was the RPN assigned to care for resident #019. RPN #134 explained that they were not familiar with resident #019 and that the Inspector should speak with the close monitoring staff for more information. RPN #164 explained that the close monitoring staff is responsible to read the information. The RPN in charge would only provide additional information if something significant had occurred.

Inspector interviewed Program Coordinator #152 who confirmed that the home's expectation is that at the beginning of every shift, each resident whose behaviours require heightened monitoring should be discussed, because those behaviours pose a potential risk to the residents. [s. 55. (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 ensuring that all direct care staff are advised at the beginning of every shift of each resident whose behaviors, including responsive behaviors, require heightened monitoring because those behaviors pose a potential risk to the resident or others, to be implemented voluntarily.

WN #14: 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 that the nutrition care and hydration program included a weight monitoring system to measure and record with respect to each resident, specifically the resident's height upon admission and annually thereafter.

During the Resident Quality Inspection Stage 1, Inspector #612 noted that out of the 40 resident sample, 31 residents did not have a height recorded since 2013 and some of the heights dated back to 2009.

Inspector interviewed Program Coordinator #136 and Manager #139, who confirmed that the home's expectation is that residents' heights are to be measured annually, and entered electronically in the resident's health care record.

Inspector reviewed the home's policy: Documentation Physical Assessments, last revised July 10, 2014. The policy indicated that 'staff are to obtain a height as part of the annual medical'. Manager #139 confirmed that if the information was not in the resident's health care record, the height assessment was not collected. [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 ensuring a weight monitoring system and record with respect to each resident, specifically the resident's height upon admission and annually thereafter, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

Inspector #543 reviewed the home's Resident Abuse/Neglect Policy which was last revised March 19, 2013.

On September 29, 2015, Inspector #543 interviewed the Director of Care regarding the home's Resident Abuse/Neglect Policy in terms of an evaluation done at least once in every calendar year. The Director of Care informed the Inspector that their policy remained in revision for the year 2014 and that there was no record or documentation of the evaluation.

On October 1, 2015, Inspector #543 interviewed the Director of Care for further clarification of the evaluation of the home's Resident Abuse/Neglect Policy, and she explained that the home does review the abuse policy and the incidents of alleged or actual abuse on a quarterly basis. The Director of Care confirmed that there was no documentation of what changes and improvements were required to prevent further occurrences, no names of the persons who participated in the evaluation, and no written records of the date that any changes or improvements were implemented. [s. 99. (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 ensuring that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remained in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident.

On September 22, 2015 at 1230hrs, Inspector #603 observed an unlocked medication cart with medications already pre-poured and ready to be administered. RPN #104 had prepared 2 injections and had pre-poured, crushed, and mixed a medication tablet in pudding. RPN #104 confirmed having prepared medications in advance and explained that they were waiting for residents to finish their lunch. All medications were prepared prior to 1200hrs when they were to be given.

On September 23, 2015, Inspector interviewed the Director of Care who explained that the staff are not to pre-pour medication and once the medication is prepared, it needs to be administered to the residents.

Inspector #603 reviewed the home's Medication Administration Policy, last revised on May 8, 2014, which indicated that 'Medications are administered at the time they are prepared. Medications are not to be pre-poured'. [s. 126.]

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 ensuring that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

i) On September 21, 2015, while observing the dining room services on a specific unit's dining room, Inspector #603 observed RPN #102 leave their unlocked medication cart, in the hallway and out of sight, while administrating medications to residents in the dining room.

Inspector #603 interviewed RPN #102 who explained that staff are expected to keep their medication cart locked at all times, when not in attendance.

ii) On September 23, 2015 at 0815hrs, Inspector #603 observed an unlocked medication cart in the hallway, outside of a unit's dining room. RPN #104 who was

responsible for the medication cart was in the dining room, serving beverages to the residents. Inspector approached RPN #104 and they responded by saying: "I know, I have to lock the medication cart".

iii) On September 25, 2015 at 0900hrs, Inspector #544 observed a locked medication cart in the hallway, outside of the dining room on a specific unit. The cart was unattended while the RPN in charge of the medication cart was providing medications to residents in the dining room. On top of the medication cart, there were 2 medications.

On September 23, 2015, Inspector interviewed the Director of Care who explained that staff are to lock their medication carts at all times when not in attendance or when out of sight.

Inspector reviewed of the home's Medication Administration Policy which was last revised May 8, 2014. The policy indicated that 'During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse'. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances were stored in a separate locked area within the locked medication cart.

On September 21, 2015 at 1200hrs, while observing the dining room services on a specific unit's dining room, Inspector #603 observed RPN #102 leave their unlocked medication cart, in the hallway and out of sight, while attending residents in the dining room. Inspector interviewed RPN #102 who explained that staff are expected to keep the medication carts locked at all times, when not in attendance.

On September 22, 2015 at 1230hrs, Inspector interviewed RPN #104 who explained that they left their locked medication cart in the medication room on a specific unit. When RPN #104 unlocked the medication room's door, Inspector observed the unlocked medication cart in the medication room. RPN #104 explained that they forgot to lock the medication cart after all.

On September 23, 2015 at 0815hrs, Inspector #603 observed an unlocked medication cart on a specific unit's hallway. RPN #104 who was in charge of the medication cart was in the dining room, serving beverages to residents.

On review of the homes policy, Medication Administration: Controlled Substances,

last revised December 30, 2013. The policy indicated that 'all controlled substances are kept in a separate locked narcotic cupboard/box, within the locked medication room/drawer', and in these cases, the controlled substances were not locked in a separate locked area within the locked medication cart. [s. 129. (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 ensuring that drugs are stored in an area or a medication cart that is secure and locked and that controlled substances are stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #18: 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. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

Inspector #543 reviewed a Critical Incident(CI) Report which was reported to the Director. The CI referred to allegations of staff to resident abuse whereby the resident was discovered in their bed calling out for help. The CI's general notes section identified that the home was to amend the CI with the outcome of their investigation.

On September 28, 2015, Inspector interviewed the Program Coordinator #136 who confirmed that the CI had not been amended with the results of the investigation. On September 28, 2015, Inspector spoke with the Director of Care who then provided the Inspector with the CI's amended copy. The amendment was only completed after the conversation with the Inspector on September 28, 2015. [s. 23. (2)]

Issued on this 4 day of February 2016 (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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
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Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
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Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : MARIE LAFRAMBOISE (628) - (A1)

Inspection No. / No de l'inspection : 2015_391603_0029 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 021579-15 (A1)

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

Report Date(s) / Date(s) du Rapport : Feb 04, 2016;(A1)

Licensee / Titulaire de permis :
THE CITY OF GREATER SUDBURY
200 Brady Street, PO Box 5000 Stn A, SUDBURY, ON, P3A-5P3

LTC Home / Foyer de SLD :
PIONEER MANOR
960 NOTRE DAME AVENUE, SUDBURY, ON, P3A-2T4

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Brenda Loubert

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To THE CITY OF GREATER SUDBURY, 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 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).

Order / Ordre :

1. The licensee shall prepare, submit, and implement a plan for achieving compliance. The plan must include:

a) That the current plan of care for resident #019 is communicated to all staff who provide care to this resident and that the care set out in the plan of care is provided to resident #019.
b) That staff assigned close monitoring for resident #019 are aware of the current plan of care and are briefed by the charge nurse, according to the home's policy.
c) That all staff, regardless of their discipline, who provide close monitoring for residents must have direct access to the resident's care plan for information.
d) That all staff providing close monitoring for resident #019 must be with the resident at all times and must be replaced, if required to leave for any reason, by staff who are knowledgeable regarding resident #019's needs.
e) What steps the licensee will take to ensure that all residents in the home are protected from abuse and/or neglect by the staff, including training on the home's abuse policies, training related to the management of responsive behaviors, and training related to the requirements to provide care to all residents, as identified in their plan of care.

This plan shall be submitted in writing to Sylvie Lavictoire, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564 3133 or email sylvie.lavictoire@ontario.ca. This plan must be submitted by January 22, 2016, with full compliance by February 5, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #016 was not neglected by staff.

Inspector #543 reviewed a Critical Incident (CI) Report which was reported to the Director. The CI related to allegations of abuse/neglect by staff towards resident #016. According to the CI, PSW #141 discovered resident #016 in their bed with the head and foot of their bed elevated, the resident curled up in the middle of the bed, their right leg over the bed rail, and left arm underneath them. The resident's call bell was found on the bedside table and not within the resident's reach.

A review of the home's internal incident report completed on a certain date, revealed alleged abuse/neglect. The incident description indicated that PSW #141 entered resident #016's room and could hear the resident calling out for help. The resident was discovered with the head and foot of the bed elevated causing the resident to be curled up and stuck in the middle. The resident's right leg was over the bed rail, and their left arm was underneath them. No call bell was near the resident, it was on the bedside table. Resident #016 was very upset and stated they were afraid to die if they fell asleep. The CI report indicated that this was the second time that resident #016 had been left unsafe, and the resident had expressed to staff their anger over the situation, stating they were very angry that they had been neglected all night.

A review of resident #016's progress note on a certain date, revealed that resident #016 stated they were awake all night and afraid to sleep because they were unable to roll over. The progress note indicated that the resident had a badge but was unable to reach it to ring for assistance.

A review of the home's investigation report identified that in an interview conducted between resident #016 and the Program Coordinator, the resident stated that they felt fearful to go to sleep and not wake up. The resident indicated that they were terrified, unable to locate their badge to call for assistance, and felt that when they really required assistance, no staff were available. Resident #016 identified that they were changed during the night, and no other staff member returned until the morning shift started.

A review of resident #016's care plan indicated that the night shift staff were to check the resident at 0230hrs, if they did not need to be changed at that time, the resident was to be changed by two staff members at 0500hrs, and that resident #016 would be repositioned at least every two hours.

A review of the resident #016's health care record specifically related to turning and repositioning revealed that 14 times in a certain month and 11 times in another month, there was no documentation to support that this resident had been turned and repositioned during the night shift.

A review of the home's Resident Abuse/Neglect Policy stated that abuse may be verbal, emotional, physical, sexual and financial or take the form of neglect. In this policy neglect was defined as withholding clothing, food, fluid, aid/assistive

devices/equipment, medication, communications and other health services or deliberately failing to meet a dependent resident's needs. (603)

2. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by PSW #155.

Inspector #543 reviewed a Critical Incident (CI) Report which was reported to the Director. The CI indicated allegations of abuse and/or neglect by PSW #155 towards resident #028. According to the CI resident #028's family was in visiting the resident when PSW #155 entered the room and the resident became visibly upset.

A review of PSW #155's personnel file revealed a history of allegations of resident abuse and neglect. The Inspector identified that during a period of time, there were 11 allegations of abuse or neglect against PSW #155 brought forward to management. A review of a letter addressed to PSW #155 confirmed that this staff member neglected to provide the required care to resident #028. (543)

3. The licensee has failed to ensure that residents were protected from abuse by resident #019.

Inspector #612 reviewed a Critical Incident (CI) Report which was reported to the Director. The report described resident to resident abuse. Resident #019 was being monitored by Behavioral Support Ontario (BSO) and had close monitoring by staff in place due to a previous incident with another resident. On a certain date, resident #020 and resident #019 wandered into another resident's room and an altercation took place. Staff overheard resident #020 yelling and the staff entered the room to find resident #020 pushing a chair, towards resident #019. Resident #019 then struck resident #020 in the face. Registered staff intervened and resident #019 and #020 were separated. Resident #020 sustained an injury but did not require a visit to the hospital.

Inspector reviewed the home's investigation notes which indicated that PSW #158 who was providing close monitoring, had turned away from resident #019 as two

other residents were becoming verbally aggressive. When PSW #158 turned their back to attend to another resident, resident #019 had left. When PSW #158 discovered that resident #019 was gone, they went to look for the resident.

Inspector reviewed resident #019's health care record. Resident #019 was admitted to the home and transferred to a specific unit, due to their behaviours. The home's internal BSO staff became involved with the resident at the time of admission, however, the resident was discharged from their services, as the resident was adjusting well on the specific unit.

On a certain date, resident #019 displayed behaviours towards resident #029 and on another date, resident #019 displayed behaviours towards resident #030's family member. Inspector confirmed with Program Coordinator #152 that no referrals, assessments, or updates to resident #019's care plan were completed to reflect resident #019's behaviours.

On a certain date, two other incidents of behaviours by resident #019 occurred towards resident #031 and #032 who were not injured and no Critical Incident Report was reported to the Director. Inspector noted that an internal BSO referral was completed after the two behaviour incidents.

On 2 specific dates, it was documented in the progress notes that resident was displaying behaviours towards other residents, particularly resident #030. Resident #019 was upset with resident #030's family while visiting with them and attempted to "go after" resident #030's family.

On a certain date, BSO S#129 completed their initial assessment, the care plan was reviewed and updated to reflect certain behaviours and triggers. The care plan indicated that staff would need to be vigilant in knowing resident #019's location, especially in the evening when behaviours were not as easy to redirect. Staff were directed to monitor resident #019 around certain residents.

On a certain date, PSW #160 found resident #019's door closed. When PSW #160 tried to enter resident #019's room, they noted that resident #033's chair was blocking the door and resident #019 walked quickly into their bathroom. PSW #160 called for assistance and stayed in the room between resident #019 and resident #033. Resident #033 sustained several injuries. Resident #019 had blood on their hands and their hands were shaking. Resident #033 was sent to hospital and the

police were notified of the incident. The police questioned resident #019 who remembered the incident and explained that resident #033 was acting inappropriately towards them. Resident #019 told the police officer that they did hit resident #033. DOS charting and one to one staffing was initiated to monitor resident #019. A Critical Incident Report was reported to the Director. Resident #019's medications were changed and a referral to external BSO was completed.

On a certain date, resident #019 was flagged for high risk behaviours and staff were alerted to new interventions in the care plan and in the shift report binder. The information included:
-Staff to be vigilant especially in evening to try to redirect resident away from specific residents. Reassure resident that you will care for specific residents and keep them safe.
- If other residents are awake and wandering in the unit, staff are to redirect them out of resident #019's home neighborhood.
- When redirecting resident #019 from specific residents, direct them to another task, attempt to engage them in an activity. Resident enjoys different activities.
- Code White to be called if resident displays certain behaviours.

On a certain date, PSW #161 assigned to stay with resident #019 left the unit without notifying another staff member. Resident #019 was found by RPN #163 in resident #034's room. Resident #019 displayed behaviours toward resident #034. RPN #163 intervened and separated residents immediately. No injuries were noted to resident #034. RPN #163 reinforced to PSW #161 that resident #019 was to have close monitoring at all times.

On July 22, 2015, 2 safety devices were placed on resident #019's door to notify staff when resident #019 left their room, or when other residents entered their room. External BSO consultant assessed the resident and they felt that the current interventions were appropriate.

Inspector reviewed the resident's progress notes which identified that there were 11 incidents of abusive behaviours by resident #019 towards other residents and 9 other incidents of responsive behaviours.

Inspector observed a certain document giving instructions for Staff providing close supervision to Resident #019. The interventions were initiated on a certain date and revised later. This document was accessible to the staff assigned to closely monitor

resident #019. The document also indicated that for each shift, the RPN on duty was responsible to review instructions with all staff on that unit, and that all staff needed to be aware of all responsibilities of the employee who was providing close supervision, and when they were to be replaced for breaks. The document included information such as the activities that the resident enjoyed and interventions to redirect resident when exhibiting certain behaviours. The same information could also be found in the resident's care plan.

Inspector attended and observed evening shift report on a certain date and day shift report on a certain date. During these 2 shift reports, resident #019's behaviours were not discussed and the staff did not discuss anything with the staff who was responsible to supervise resident #019. Inspector interviewed the charge RPN #134, who explained that they were not familiar with the resident and that Inspector should speak with the close monitoring staff for more information. RPN #164 stated that the close monitoring staff were responsible to read the information about the resident they were caring for and registered staff would only provide additional information if something significant had occurred.

Inspector interviewed Dietary Aid #165 who was providing close monitoring for resident #019. Dietary Aid #165 was unable to provide Inspector with information regarding resident's triggers or behaviours. Dietary Aid #165 stated that they were not provided with any information at the start of the shift to indicate what resident #019's behaviours were like or what triggers to watch for. Dietary Aid #165 did not have access to resident #019's care plan which was confirmed by Program Coordinator #152. Dietary Aid #165 explained that they were familiar with resident #019 as they were the dietary aid that usually worked in the same dining room as resident #019 dined in. Dietary Aid #165 also explained that if they observed a change in resident's behaviour, they would call for assistance.

On September 30, 2015, at 1036hrs, Inspector entered the common area of a certain unit and observed resident #019 sitting alone at a table. There were other residents including specific residents, who were walking past resident #019 and there were no staff present. At one point, RPN #164 walked into the common area and Inspector inquired about the whereabouts of the close monitoring staff. RPN #164 was not able to respond to this question. As Inspector and RPN #164 started to look for the close monitoring staff, the close monitoring staff returned to the unit and explained that they had gone down the hallway to get wash cloths to fold. During this time, resident #019 was out of Dietary Aid #165's sight and RPN #164 reinforced to

Dietary Aid #165 that the close monitoring staff must stay with resident at all times.

LTCHA, 2007 S.O. 2007, s. 19. (1) was issued previously as WN and CO during Inspection #2013_138151_0030, a WN and VPC during Inspection #2012_140158_0002. The scope of this issue was a pattern and the severity was determined to be actual harm/risk to residents. (612)

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

Feb 05, 2016

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

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

The licensee shall prepare, submit, and implement a plan to ensure that the home's current written policy entitled Resident Abuse/Neglect, is complied with. The plan shall include the following:

1. Steps the licensee will take to ensure that all staff, including management staff, receive retraining on the home's current policy Resident Abuse/Neglect.

2. An auditing process to ensure that all staff receive training during orientation and annual retraining on the home's policy Resident Abuse/Neglect.

This plan shall be submitted in writing to Sylvie Lavictoire, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564 3133 or email sylvie.lavictoire@ontario.ca. This plan must be submitted by January 22, 2016, with full compliance by February 5, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that the Resident Abuse/Neglect Policy was complied with.

On September 29, 2015, Inspector #603 reviewed a Critical Incident (CI)Report which alleged staff to resident abuse and was reported to the Director. The CI indicated that on a certain date, resident #024 reported that a PSW had argued about the number of personal supplies the resident could take with them on a leave. During this time the PSW allegedly struck the resident on the arm with the personal supply. The resident reported that the PSW put their foot out to protect themself, and the PSW stated the resident kicked them.

Inspector reviewed the home's investigation report and on a certain date, resident #024 reported the alleged abuse to Behavioral Support Ontario #153 who then reported this to RN #151, who then reported this to the Director of Care. On the next day, the Director of Care reported the alleged abuse to the Director.

Inspector reviewed the home's policy Abuse: Resident Abuse/Neglect, last revised March 19, 2013, which indicated that 'certain persons, including staff members who witness, to make an immediate report to the MOHLTC Director where there is a reasonable suspicion that the following incidents occurred or may have occurred: 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'. (603)

2. The licensee has failed to ensure that the Resident Abuse/Neglect Policy was complied with.

On September 29, 2015, Inspector #627 reviewed a Critical Incident (CI) which alleged staff to resident abuse and was reported to the Director. The CI indicated that on a certain date, a staff member was in one specific unit's dining room when they overheard a Nutritional Aide (NA) yelling loudly at someone. They looked to see what was happening and saw the NA standing at a table yelling loudly at a resident, "Don't you ever do that to me again, or else, you people don't appreciate me". The staff member witnessed resident #022 sitting in the chair with a fearful look on their face.

Inspector reviewed the investigation report which indicated that RPN #146 who witnessed the incident reported the incident to the Food Supervisor #147, Manager of Food Services #148 and to the Program Coordinator #145, on a certain date.

Inspector interviewed Program Coordinator #145 who confirmed that they reported the incident to the Director, one day later. Program Coordinator #145 explained that since the incident occurred on Sunday, they did not get the email until Monday, when they submitted the CI to the Director.

Inspector #627 reviewed the home's policy Abuse: Resident Abuse/Neglect, last revised March 19, 2013, which indicated that 'certain persons, including staff members who witness, to make an immediate report to the MOHLTC Director where there is reasonable suspicion that the following incidents occurred or may have occurred: Abuse of a resident by anyone or neglect of a resident by the licensee or a staff that resulted in harm or a risk of harm to the resident. The staff member who witnesses any of the above incidents is to contact the MOHLTC on their own or if they wish with the assistance of their manager but do not have a choice to not report as it is an offence under the LTCHA'.

Inspector #627 interviewed the Director of Care who explained that the policy states that an incident of abuse needs to be reported immediately and that any staff member who witnesses abuse is to call the on call manager when there are no managers working, and then the manager on call will call the Action Line to report to the Director. (627)

3. The licensee has failed to ensure that the Resident Abuse/Neglect Policy was complied with.

Inspector #544 reviewed a Critical Incident (CI) Report which alleged abuse by staff toward resident #025 while being fed during a lunch meal on a certain date. Resident #025 was eating slowly and had their eyes closed. Food Supervisor #144 observed a PSW feeding resident #025 and witnessed and heard the PSW say in a loud voice, "if you are not going to eat for me, I'm going to leave and look after someone else".

Inspector reviewed the home's investigation report and PSW #127 was identified. The home determined that the incident occurred but the incident was not abusive in nature. The Program Coordinator felt that the tone of PSW #127's voice may have been interpreted by other staff, residents, and families as an angry, unprofessional, demeaning and/or uncaring tone and manner. The home determined that the incident was unsubstantiated, however, a discipline letter was given to PSW #127.

Inspector #544 reviewed the home's Resident Abuse/Neglect Policy, last revised March 19, 2013, which indicated that verbal abuse is any form of verbal communication of a threatening or intimidating nature or 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'. The policy also indicated that 'the home area Program Coordinator must notify the resident's Substitute Decision Maker (SDM) immediately upon becoming aware of an alleged, suspected or witnessed incident of abuse or neglect that causes distress to the resident that could potentially be detrimental to the resident's health or well-being'.

Inspector #544 reviewed resident #025's health care record and there was no documentation that this incident had occurred or that the SDM was notified of the allegation of abuse on a certain date. Inspector interviewed MDS Coordinator #122 and PSW #125 who confirmed that the SDM had not been notified of the allegation. (544)

4. The licensee has failed to ensure that the Resident Abuse/Neglect Policy was complied with.

Inspector #543 reviewed a Critical Incident (CI) Report related to alleged abuse which was reported to the Director. The CI indicated that PSW #150 was verbally abusive towards resident #017. On a certain date, the resident informed staff that on a specific date, PSW #150 threatened the resident by saying "If you hurt me, I will hurt you". The CI described that during an interview with resident #017 it was discovered that the incident occurred on a certain date and the report was filed with the Director 3 days later.

A review of the home's internal investigation revealed that in an email, RN #151 informed the Program Coordinator that two PSWs reported to them that resident #017 brought forward a concern that PSW #150 was verbally abusive to the resident while providing care. A letter addressed to PSW #150 indicated that the way they spoke to resident #017 was interpreted as threatening and unprofessional. On a certain date, in a meeting held with PSW #150 and the Program Coordinator, PSW #150 was informed that resident #017 no longer wanted to receive care from them.

A review of the home's Resident Abuse/Neglect Policy, indicated that verbal abuse is defined as any form of verbal communication of a threatening or intimidating nature. The policy noted that any employee who witnesses, or becomes aware of, or suspects resident abuse shall report it immediately to the Registered Staff, Program Coordinator, Manager of Resident Care or Director who will conduct a thorough and confidential investigation. [s. 20. (1)]

2. The licensee has failed to ensure that the Resident Abuse/Neglect Policy was complied with.

Inspector #544 reviewed a Critical Incident (CI) Report which alleged abuse by staff toward resident #025 while being fed during a lunch meal on a certain date. Resident #025 was eating slowly and had their eyes closed. Food Supervisor #144 observed a PSW feeding resident #025 and witnessed and heard the PSW say in a loud voice, "if you are not going to eat for me, I'm going to leave and look after someone else".

Inspector reviewed the home's investigation report and PSW #127 was identified. The home determined that the incident occurred but the incident was not abusive in nature. The Program Coordinator felt that the tone of PSW #127's voice may have been interpreted by other staff, residents, and families as an angry, unprofessional,

demeaning and/or uncaring tone and manner. The home determined that the incident was unsubstantiated, however, a discipline letter was given to PSW #127.

Inspector #544 reviewed the home's Resident Abuse/Neglect Policy, last revised March 19, 2013, which indicated that verbal abuse is any form of verbal communication of a threatening or intimidating nature or 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'. The policy also indicated that 'the home area Program Coordinator must notify the resident's Substitute Decision Maker (SDM) immediately upon becoming aware of an alleged, suspected or witnessed incident of abuse or neglect that causes distress to the resident that could potentially be detrimental to the resident's health or well-being'.

Inspector #544 reviewed resident #025's health care record and there was no documentation that this incident had occurred or that the SDM was notified of the allegation of abuse on a certain date. Inspector interviewed MDS Coordinator #122 and PSW #125 who confirmed that the SDM had not been notified of the allegation.

LTCHA, 2007 S.O. 2007, s. 20 (1) was issued previously as WN during Inspection #2015_282543_0018, a WN and VPC during Inspection #2012_140158_0002. The scope of this issue was widespread and the severity was determined to be minimal harm or potential for actual harm. (543)

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

Feb 05, 2016

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee shall ensure that all staff and others who provide direct care to residents shall immediately report the suspicion and the information of any alleged or actual abuse to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in risk of harm immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #612 reviewed a Critical Incident (CI) Report which was reported to the Director. The report described abuse by resident #019 towards resident #020. Resident #020 sustained an injury.

Inspector reviewed resident #019's health care records and noted 2 incidents of physical abuse on a specific day, involving resident #019 towards resident #031 and #032.

Inspector interviewed Program Coordinator #152 and requested the Critical Incident Report from the specific incidents. Program Coordinator #152 stated that since there was no physical injury to resident #031 and resident #032, the home's decision was that no Critical Incident Report would be completed.
(612)

2. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #628 reviewed a Critical Incident (CI) Report which was reported to the Director. The CI indicated that on a specific date, resident #026 reported to their family member that they did not like being in the home any longer, as they were yelled at by PSW #156 because the resident could not feed themself. The alleged incident happened on a specific date and was not reported to the Director until 3 days later. The report indicated that on a certain date, RPN #157 reported the incident to Program Coordinator #145 via email and Program Coordinator #145 did not receive the email until 3 days later, when Program Coordinator #145 reported to the Director of Care.

Inspector interviewed the Director of Care who explained that staff are expected to report any alleged abuse immediately and in this case, RPN #157 should not have left an email and should have called either the Ministry to report or the Administrator on call.
(628)

3. The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff, immediately reported the suspicion and the information upon which it was based to the Director.

On September 29, 2015, Inspector #603 reviewed a Critical Incident (CI) which was reported to the Director on a specific date. The CI indicated that resident #024 reported on the evening before, that a PSW had argued about the number of personal supplies the resident could take with them on a leave. During this time the PSW allegedly struck resident #024 on the arm with the personal supply. The resident reported they put their foot out to protect themself, and the PSW stated the resident kicked them.

Inspector reviewed the home's investigation report which indicated that the Behavioral Support Ontario staff #153 reported the resident's concerns to the RN #151 on a specific day, who then reported this information to the Director of Care to make the report to the Director, one day later.
(603)

4. The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff, immediately reported the suspicion and the information upon which it was based to the Director.

On September 29, 2015, Inspector #627 reviewed a Critical Incident(CI) Report which was reported to the Director. The CI indicated that on a certain date, a staff member in a specific unit's dining room when they overheard a Nutritional Aide (NA) yelling loudly at someone. They looked to see what was happening and saw the NA standing at a table yelling loudly at a resident, "Don't you ever do that to me again, or else, you people don't appreciate me". The staff member witnessed resident #022 sitting in the chair with a fearful look on their face.

Inspector interviewed the Program Coordinator #145 who confirmed that they reported the incident to the Director on a specific date. The RPN #146 who witnessed the incident had reported the incident to the Food Supervisor #147, Manager of Food Services #148 and to the Program Coordinator #145, a day earlier. The Program Coordinator #145 explained that since the incident occurred on a Sunday, they did not get the email until the Monday, when they submitted the CI to the Director.

Inspector interviewed the Director of Care who explained that it was the home's expectation that any incident of abuse needs to be reported immediately. The Director of Care explained that a staff member who witness abuse is to call the on call manager when there are no managers working, and then the manager on call will call the Action Line to report to the MOHLTC.

LTCHA, 2007 S.O. 2007, s. 24. (1) was issued previously as WN during Inspection #2015_282543_0018, a WN and VPC during inspection #2012_140158_0002. The scope of this issue was a pattern and the severity was determined to be minimal harm or potential for actual harm. (627)

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

Jan 22, 2016

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all staff and others who provide direct care to residents receive training on the following policies:

1. 'Skin Care (Cross reference Skin Integrity-Preventive Assessment and Treatment)', last revised May 1, 2014, specifically that assigned PSWs are to complete a full resident head to toe assessment once per week and report all concerns to registered staff immediately and registered staff are to complete weekly wound assessment for all residents who have skin breakdown, according to policy.
2. 'Responsive Behaviours Prevention, Assessment and Management of', last revised December 5, 2014, specifically ensuring that if a resident demonstrates escalating, potentially injurious behaviours, DOS charting is initiated immediately and resident is referred to BSO.
3. 'Medication Administration', last revised May 8, 2014, specifically ensuring the dignity and privacy of the resident is maintained and that eye/ear drops, inhalers, patches, g-tube or any type of injections are not to be administered in a public area, ie dining room, nursing station, lounge, etc.

The licensee will develop and implement an auditing process to ensure that the above policies are implemented by all staff who provide direct care to residents.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's policy related to Skin and Wound Assessment was complied with.

On September 23, 2015, Inspector #603 interviewed PSW #125 who was caring for resident #007. PSW #125 explained that the resident had 2 wounds. One of the wounds required a dressing change and the other wound no longer required a dressing change.

On September 23, 2015, Inspector reviewed the Wound Assessment Record Binder on a specific unit. In the binder, there were 2 identified Wound Assessment Record reports for resident #007. One report had 2 specific wounds and one of these wound assessments was due on a specific date, but was last done 7 days prior to the due date. The other wound assessment was due on a specific date but was last done one week prior. RPN #124 confirmed that the weekly wound assessments were not completed as required.
(603)

2. The licensee has failed to ensure that the home's policy related to Skin and Wound Assessment was complied with.

Inspector #544 reviewed resident #002's health care record which indicated that the resident had a wound. This wound opened on a certain date, and was closed 13 days later. Fourteen days after the wound had closed, the same wound opened and an initial wound care assessment was conducted by the wound care nurse.

The next weekly wound care assessment was to be conducted on a certain date. Inspector reviewed resident #002's health care record which did not include documentation to support the completion of that assessment and PSW #127 and RPN #106 confirmed that this assessment was not completed.

Inspector reviewed the home's policy Skin and Wound Assessment, last revised January 15, 2014. The policy indicated: 'All residents of Pioneer Manor with skin breakdown will have their wounds assessed at least weekly by a registered staff member...and outcomes documented in the resident's chart'.

Inspector reviewed resident #002's health care record which did not include documentation to support that a head to toe assessment was completed on a certain date, which was the resident's first bath day of the week. PSW #127, RN #128 and RPN #106 confirmed that there was no assessment done.

Inspector reviewed the home's Skin Care Policy (Cross reference Skin Integrity-Preventive Assessment and Treatment), last revised May 1, 2014. The policy indicated: 'The assigned Health care Aide (HCA), is to complete a full head to toe assessment once per week and report all concerns to registered staff immediately. Assessment completed on the bath day in which the resident's linen is changed'. (544)

3. The licensee has failed to ensure that the home's policy Responsive Behaviours Prevention, Assessment and Management of, was complied with.

Inspector #612 reviewed Critical Incident (CI) Report #M566-000036-15 which was reported to the Director on September 11, 2015. The CI described resident #019 being physically abusive towards resident #020.

Inspector noted that resident #019 displayed physical and verbal responsive behaviours on three different dates, April 15, 2015, May 13, 2015, and May 31, 2015. Inspector confirmed with Program Coordinator #152 that no referrals were completed for BSO involvement.

On June 24, 2015, resident #019 displayed two more physically responsive behaviours, once toward resident #031 and once toward resident #032. Resident #031 and #032 did not sustain any injury. After the two incidents, a referral was completed for BSO involvement for resident #019's responsive behaviours.

Inspector #612 reviewed the home's policy Responsive Behaviours Prevention, Assessment and Management of, last revised December 5, 2014. The policy indicated that 'All residents who are presenting with responsive behaviours will be referred to BSO'.

Inspector interviewed the Program Coordinator #152 who explained that BSO would be referred to, in the event that any resident is displaying increased responsive behaviours. (612)

4. The licensee has failed to ensure that the home's policy related to Medication Administration was complied with.

i) On September 22, 2015 at 1230hrs, Inspector #603 observed medications already pre-poured and ready to be administered, located in the medication room. Inspector observed that RPN #104 had prepared specific injections and had pre-poured, crushed, and mixed a medication tablet in pudding. RPN #104 confirmed having prepared medications in advance and explained that they were waiting for the residents to finish lunch. All medications were prepared prior to 1200hrs, when they

were to be given.

On September 23, 2015, Inspector interviewed the Director of Care who explained that staff are not to pre-pour medications and once the medications are prepared, the staff need to administer the medications to the residents.

Inspector #603 reviewed the home's Medication Administration Policy, last revised May 8, 2014. The policy indicated that 'Medications are administered at the time they are prepared and medications are not to be pre-poured'.

ii) On September 21, 2015 at 1200hrs while observing the dining room services in a specific dining room, Inspector #603 observed RPN #102 leave their unlocked medication cart in the hallway, while in the dining room. Inspector interviewed RPN #102 who explained that staff are expected to keep the medication carts locked at all times when not in attendance.

On September 22, 2015 at 1230hrs, Inspector #603 interviewed RPN #104 who explained that they had left their locked medication cart in the medication room on a specific unit. When RPN #104 unlocked the medication room's door, Inspector observed an unlocked medication cart. RPN #104 explained that they forgot to lock the medication cart after all, which is contrary to the home's policy.

On September 23, 2015 at 0815hrs, Inspector #603 observed an unlocked medication cart in a specific hallway. RPN #104 who was in charge of the medication cart was in the dining room, serving beverages to residents, and the medication cart was out of sight.

Inspector #603 reviewed the home's Medication Administration Policy, last revised May 8, 2014. The policy indicated that 'all medication carts and medication room are to be locked at all times when the registered nursing staff is not in attendance or does not have the cart within vision'.

iii) On September 21, 2015, Inspector #612 observed 2 tubes of medication in resident #008's bathroom. There was no pharmacy label on either tube. Inspector also observed another medication tube in resident #015's room. The tube had a pharmacy label on it.

During an interview with RPN #130, they explained that the home's expectation is

that no medication will be left at the bedside and once medication has been administered, it will be returned to the medication nurse for appropriate storage.

On September 25, 2015, Inspector reviewed the home's policy Medication Administration, last revised on May 8, 2014. The policy indicated that 'all areas where drugs are stored shall be locked at all times, when not in use'.

iv) On September 22, 2015, Inspector #603 observed the medication administration on a specific unit during 1200-1230hrs. At 1200hrs, Inspector observed RPN #103 administer an injection to resident #018's left arm while sitting in their wheelchair, in the hallway adjacent to the unit's dining room. Inspector interviewed RPN #103, who explained that they would normally give the injection in the resident's room but because the resident was already in the dining room, they wheeled the resident away from the dining room into the hallway, to give the injection. RPN #103 explained that it is the home's expectation to administer injections in the resident's room.

On September 23, 2015 at 0940hrs, Inspector interviewed the Director of Care who explained that it is the home's expectation that all treatments including injections, be administered in the resident's room.

On September 28, 2015 at 1130hrs, Inspector interviewed resident #018 who explained that they receive their injection in their room or in the dining room as the injections are due at meal times.

On September, 28, 2015, Inspector reviewed the home's Medication Administration Policy, last revised on May 8, 2014. Under General Guidelines, the policy indicated: 'To ensure the dignity and privacy of the resident is always maintained, eye/ear drops, inhalers, patches, g-tube or any type of injections are not to be administered in a public area, ie dining room, nursing station, lounge, etc.'

The decision to issue this compliance order was based on the scope which was widespread and the severity which indicated actual harm/risk.
(603)

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Feb 05, 2016

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to ensure that the staffing mix is consistent with residents' assessed care and safety needs, and that meets the requirements set out in the Act and this Regulation. The plan shall include the following:

1. Steps the licensee will take to ensure that all residents receive their preferred and scheduled baths that have been identified in their care plan.
2. That resident #019 receives close monitoring by staff as identified in their plan of care.
3. An auditing process to ensure that all residents receive their assessed care and safety requirements according to their care plans.

This plan shall be submitted in writing to Sylvie Lavictoire, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564 3133 or email sylvie.lavictoire@ontario.ca. This plan must be submitted by January 22, 2016, with full compliance by February 5, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

Inspector #612 interviewed resident #004, #008, and #012 who stated that the home is always short of PSWs and that they do not get their tub baths as scheduled.

Inspector reviewed resident #004, #008, #009, #012, #013, and #014's health care records. Inspector noted that during a period of time (one month), resident #004 had 5 bed baths and 3 tub baths; resident #008 had 2 bed baths and 3 tub baths; resident #009 had 2 bed baths and 5 tubs baths; resident #012 had 5 bed baths and 3 tub baths; resident #013 had 6 bed baths and 3 tub baths; and resident #014 had 3 bed baths. Inspector reviewed their care plans and noted that for all of these residents, their preference was a tub bath.

Inspector #544 interviewed the President of the Family Council who stated that insufficient staffing and tub baths not being completed, have been ongoing issues and have been discussed multiple times at Family Council meetings. The

Administrator attended the meeting in June, however, members of the Council felt that these issues were still persisting, and felt that no concrete solution had been presented.

Inspector #612 interviewed PSWs #118, #127, #119, and #126 who explained that they work short almost daily on any unit. They explained that when they are short staffed, they will give bed baths instead of tub baths or showers, as there is not enough time.

Inspector #612 interviewed BSO RPN #129 who explained that for a period of 2 weeks, they were pulled from their regular duties of BSO for 2.5 of their 8 shifts to do nursing duties. During this time, the BSO work did not get done.

Inspector #612 interviewed Therapy Manager #135 who explained that the home's expected target referral time between BSO to initial contact with the resident was 24hrs, however, the wait time was much longer due to BSO staff being pulled for other nursing duties. Therapy Manager #135 explained that between January and March, 2015, the average time between initial referral to BSO and initial contact with resident was 60hrs. Between April and June, 2015, it was 67.3hrs, and between July and September, 2015, 58.46hrs.

Inspector was provided with an excel tracking document from Administration Manager #140. This document indicated that between September 1 - 27, 2015, the home was short staffed 6.7% of Personal Support Worker (PSW) shifts, 2.8% of Registered Practical Nurse (RPN) shifts, and 1.7% of Registered Nurse (RN) shifts.

Inspector interviewed the Director of Care who confirmed that the direction to the PSWs had been that when they were short staffed on a unit, bed baths were to be completed instead of the resident's preferred method of bathing.

LTCHA, 2007 S.O. 2007, r.31.(3) was issued previously as WN and VPC during Inspection #2012_138151_0017. The scope of this issue was widespread and the severity was determined to be minimal harm or potential for actual harm. (612)

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Feb 05, 2016

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

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

The licensee shall ensure that all staff and others who provide direct care to residents take steps to minimize the risk of altercations and potentially harmful interactions between and among residents, by implementing the home's current policy 'Responsive Behaviours Prevention, Assessment and Management of', specifically ensuring that:

1. All residents who are presenting with responsive behaviours will be referred to BSO according to the policy.
2. All residents requiring close monitoring by staff will be provided that care according to their plan of care and the Responsive Behaviours Policy.
3. All residents presenting with responsive behaviours and who pose a risk of potentially harmful interactions with other residents will be reported through shift-to-shift reporting methods and staff will follow the 'Cross Reference Resident Care, Documentation Shift to Shift Report' policy and procedure.
4. Training is to be provided to all direct care staff related to the 'Responsive Behaviours Prevention, Assessment and Management of' and 'Cross Reference Resident Care, Documentation Shift to Shift Report' policies.

Grounds / Motifs :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions for resident #019 by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations.

Inspector #612 reviewed resident #019's health care record. Resident #019 was admitted and transferred to a specific unit due to specific behaviours. The home's internal BSO staff became involved with the resident at the time of admission however, the resident was discharged from their services, as the resident was adjusting well on the specific unit.

On a certain date, resident #019 displayed certain behaviours towards resident #029 and on a certain date, resident #019 became upset and attempted to hit resident #030's family member.

Inspector confirmed with Program Coordinator #152 that at that time, no referrals, interdisciplinary assessments, or updates to resident #019's care plan to identify interventions were completed, to reflect resident's certain behaviours.

On June 24, 2015, resident #019 displayed two more behaviours, once toward resident #031 and once toward resident #032.
(612)

2. The licensee has failed to ensure that the steps taken to minimize the risk of altercations and potentially harmful interactions from resident #019 were implemented.

Inspector reviewed resident #019's health care record which indicated that the resident displayed behaviours toward other residents on 2 specific days. Inspector confirmed with the Program Coordinator #152 that no referrals, interdisciplinary assessments, or updates to resident #019's care plan were completed to reflect resident's behaviours. After two behaviour incidents on a specific date, an internal BSO referral was completed and the Dementia Observation Sheet (DOS) was initiated.

On 2 specific dates, it was documented that resident #019 was displaying behaviours towards other residents, particularly resident #030. Resident #019 was upset with resident #030's family visiting with them and attempted to "go after" resident #030's family. BSO #129 completed their initial assessment, the care plan was reviewed and updated to reflect verbal and physical responsive behaviours. Included in the assessment was that staff will need to be vigilant in knowing resident #019's location, especially in the evening when behaviours are not easily redirected. It was noted that staff needed to monitor resident #019 around specific residents.

On a certain date, PSW #160 found resident #019's door closed. When PSW #160 entered resident #019's door, they observed that resident #033's chair was blocking the door and resident #019 walked quickly into their bathroom. PSW #160 called for assistance and stayed in the room between resident #019 and resident #033. Resident #033 had sustained several injuries. Resident #019 had blood on their hands and their hands were shaking. Resident #033 was sent to hospital and the police were notified.

On a certain date, resident #019 was flagged for high risk behaviours, staff were alerted to new interventions, and the information was added in the care plan and in the shift report binder.

On a certain date, PSW #161 who was assigned to stay with resident #019 left the unit without notifying another staff member. Resident #019 was found by PSW #163 in resident #034's room. Resident #019 had displayed behaviours towards a resident. The registered staff reinforced that resident #019 was to have close monitoring staff present at all times.

Inspector reviewed progress notes during a certain period of 2 months. The notes described resident #019 exhibiting increasing behaviours toward other residents. The same notes described resident #019 exhibiting physically responsive behaviours.

Inspector reviewed a Critical Incident (CI) which was reported to the Director. The CI described resident to resident abuse. Resident #019 was being monitored by Behavioral Support Ontario (BSO) and close monitoring staff, due to a previous incident with a specific resident. PSW #158 who was close monitoring resident #019 turned their attention away from resident #019, when they turned back, they were unable to locate resident #019.

Resident #019 and resident #020 had wandered into another resident's room and an altercation took place between them. Staff overheard resident #020 yelling and entered the room to find resident #020 pushing a chair towards resident #019. Resident #019 then struck resident #020 in the face. Registered staff intervened and resident #019 and #020 were separated. Resident #020 sustained an injury.

Inspector interviewed the Program Coordinator #152 who explained that the direction provided to staff was that the close monitoring staff member was to keep resident #019 in their field of vision at all times.

On a specific date, Inspector entered a specific unit and observed resident #019 sitting alone at a table. There were other residents walking past resident #019. No staff was present. RPN #164 then walked into the common area and Inspector inquired where the close monitoring staff was, and RPN #164 was not able to explain where the close monitoring staff was. The close monitoring staff returned to the unit and explained that they had left to get wash cloths for the resident to fold.

The decision to issue this compliance order was based on the scope which was isolated and the severity which was determined to be actual harm/risk to other residents.
(612)

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

Feb 05, 2016

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that where bed rails are used;

a) The resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.
b) Steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.
c) Other safety issues related to the use of bed rails are addressed, including height and latch reliability.
d) A record is kept to indicate for each resident where bed rails are used, when the resident was assessed and his or her bed system was evaluated.
e) The licensee shall review and revise the policy Restraint Use (Least Restraint), to include requirements under a, b, c, and d.
f) The licensee shall educate all staff and others who provide direct care to residents related to the revised policy and shall implement the new policy.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, the resident had been assessed and their bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Inspector #612 reviewed resident #008, #009, and #010's health care records. All three residents used bed rails and their health care records indicated a focus for bed rails. There was no assessment related to the residents and their bed system.

Inspector interviewed RPN #104, RPN #131, and RN #137 who explained that these assessments are to be completed by Occupational Therapists. Therapist #138 confirmed that they complete residents' bed system assessments however, they were unable to locate these for resident #008, #009, and #010.

Inspector interviewed the Therapy Manager #135 who explained that the home updated their policy in December, 2014, and started assessing the residents and their bed systems for all new admissions beginning January, 2015. Previously, assessments were only completed on residents and beds with therapeutic surfaces or if a problem was identified by the staff. There were only records to indicate that residents and beds were assessed if they had a therapeutic surface. Inspector noted that between January 1 and September 24, 2015, residents #008, #009, and #010 were not assessed and their bed systems were not evaluated.
(612)

2. The licensee has failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Inspector #612 reviewed resident #008, #009, and #010's health care records. All three residents used bed rails and their health care records indicated a focus for bed rails. Inspector was unable to locate information which included steps taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Inspector interviewed RPN #104, RPN #131, and RN #137 who explained that the resident and bed system assessments are to be completed by Occupational Therapists. Therapist #138 confirmed that they complete bed system assessments, however, they were unable to locate these for resident #008, #009, and #010.

Inspector noted that between January 1 and September 24, 2015, resident #008, #009, and #010's bed were not assessed and steps were not taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. (603)

3. The licensee has failed to ensure that where bed rails were used, other safety issues related to the use of bed rails were addressed, including height and latch reliability.

Inspector #612 reviewed resident #008, #009, and #010's health care records. All three residents used bed rails and their health care records indicated a focus for bed rails. Inspector was unable to locate a bed system assessment which included height and latch reliability.

Inspector interviewed RPN #104, RPN #131, and RN #137 who stated that the assessment related to the resident and their bed system which include height and latch reliability of bed rails, are to be completed by Occupational Therapists. Therapist #138 confirmed that they complete these assessments, however, they were unable to locate the assessments for residents #008, #009, and #010.

The decision to issue this compliance order was based on the scope which showed a pattern and the severity which indicated a potential for actual harm for residents using bed rails.

(603)

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

Apr 15, 2016(A1)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. The plan will include the following:

1. A process to ensure that the care set out in the current plan of care for each resident is provided to the resident as specified in the plan.
2. An auditing process that will identify when staff are not providing care as specified in the plans so that corrective action can be taken.
3. A multidisciplinary process to ensure clear communication between RNs, RPNs, and PSWs related to the requirements in residents' plans of care.

This plan shall be submitted in writing to Sylvie Lavictoire, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564 3133 or email sylvie.lavictoire@ontario.ca. This plan must be submitted by January 22, 2016, with full compliance by February 5, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #016 as specified in the plan.

Inspector #543 reviewed documentation and identified the following in an interview conducted on a certain date, with resident #016 and Program Coordinator #136.

-the resident stated that it seems like when they really need someone, no one comes and that staff should check on them at least every 2 hours.
-the resident stated that after staff changed them they are supposed to put the badge on their right side. The resident started calling for help, and no one came until the regular staff in the morning.

Inspector reviewed the resident's care plan which indicated that the night shift staff were to check the resident at 0230hrs, if they did not need to be changed at that time, they were to be changed by 2 staff members at 0500hrs and that resident #016 would be repositioned at least every 2 hours.

Inspector reviewed the Point of Care (POC) Resident Response Rate Report regarding turning and repositioning resident #016 every 2 hours for 2 months, and identified the following:

For the first month, a total of 90 responses were entered in POC. For 13% of the time, there was no documentation to support that resident #016 was turned and positioned.

For the second month, a total of 93 responses were entered in POC. For 11% of the time, there was no documentation to support that resident #016 was turned and positioned.
(543)

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #008 as specified in the plan.

Inspector #544 reviewed resident #008's health care records which indicated that the resident had 6 falls during a specific period of time.

Inspector reviewed resident #008's care plan which had a focus for High Risk for Falls and the interventions included hourly night shift visual checks or more often to ensure safety and respond to the resident's needs. Visual checks were to be recorded.

On review of resident #008's health care record, Inspector identified no documentation that supported the night shift hourly checks for resident #008.

Inspector interviewed RPN #134, who confirmed that these checks were not done as the staff were not aware of this requirement.

LTCHA, 2007 S.O. 2007, s. 6. (7) was issued previously as WN during Inspection #2014_283544_0021, a WN and CO during Inspection #2013_246196_0003, a WN and VPC during Inspection #2013_138151_0016, a WN during Inspection #2012_140158_0015, a WN during Inspection #2012_140158_0013, and a WN during Inspection #2012_140158_0005. The scope of this issue was a pattern and the severity was determined to be minimal harm or potential for actual harm. (544)

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

Feb 05, 2016

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

Order # / Ordre no : 009

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

Pursuant to / Aux termes de :

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

Order / Ordre :

Ontario

Order(s) of the Inspector
Ordre(s) de l'inspecteur

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

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

The licensee shall prepare, submit, and implement a plan to ensure that there is a plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident. The plan will include the following:

1. A process to ensure that the plan of care for each resident is reviewed, updated, and identifies clear and current directions to enable staff and others who provide direct care, to appropriately care for each resident.
2. A process to ensure that the plan of care is clearly communicated to and understood by all staff and others who provide direct care to the residents.
3. An auditing process for written plans of care that will identify problems, gaps, and indicate corrections needed to provide clear direction to staff and others who provide direct care to the residents.
4. Education and retraining for all staff involved in developing residents' written plans of care, including the risks associated with the lack of clear directions to staff and others who provide direct care to the residents.
5. A multidisciplinary process to ensure clear communication between RNs, RPNs, and PSWs, so that the plans of care always provide clear directions to staff and others who provide direct care to the residents.

This plan shall be submitted in writing to Sylvie Lavictoire, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564 3133 or email sylvie.lavictoire@ontario.ca. This plan must be submitted by January 22, 2016, with full compliance by February 5, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #019.

Inspector #612 reviewed resident #019's care plan which indicated that the resident had a wound. Inspector interviewed Program Coordinator #152 who explained that the resident did not have a wound. The care plan also referred to universal precautions being in place for fall prevention including using an assistive device. However, under mobility, the care plan indicated that the resident mobilized independently without any assistive device.

On multiple occasions, Inspector observed the resident ambulating independently and Program Coordinator #152 confirmed that resident #019 ambulated independently.
(612)

2. The licensee failed to ensure that the plan of care set out clear direction to staff and others who provide direct care to resident #009.

On multiple occasions during the inspection, Inspector #612 observed resident #009 with a half bed rail engaged on the right side of their bed and an assist bed rail (not engaged) on the left side of their bed.

Inspector interviewed PSW #118 and RPN #131 who were unable to explain why the resident had a half rail engaged on the right side of their bed. PSW #118 and RPN #131 stated that the resident used the assist rail on the left side and that the information would be found in the care plan.

Inspector reviewed resident #009's care plan which did not contain any focus, goals, or interventions relating to the use of bed rails.

Inspector interviewed Program Coordinator #136 who confirmed that the information related to resident #009's bed rail use should be in their care plan, however it was not. (612)

3. The licensee has failed to ensure that the plan of care set out clear direction to staff and others who provide direct care to resident #002.

Inspector #612 reviewed the bathing schedule for resident #002 and noted that they received bed baths on Sundays and tub baths on Wednesdays.

Inspector reviewed the resident's care plan which indicated that the resident received bed baths on Sundays and tub baths on Thursdays.

Inspector interviewed PSW #118 and PSW #127, and RPN #106 who confirmed that resident #002 received bed baths on Sundays and tub baths on Wednesdays. (612)

4. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #007.

On September 23, 2015, Inspector #603 observed resident #007 sleeping in their bed with an air mattress on the bed. Inspector interviewed PSW #125 who explained that resident #007 had 1 wound which a dressing was required.

Inspector reviewed resident #007's care plan and there was no focus for altered skin integrity or skin and wound care. Inspector reviewed the Skin and Wound binder on the specific unit. In the binder, resident #007 had a list of current wounds which included 2 wounds. Inspector reviewed the Wound Assessment Record which referred to 2 different wounds. On the 'Scheduled MAR/TAR Events Report', there was only one focus for a wound. RPN #124 confirmed that there was discrepancy between the reports and that the resident still had only one wound.
(603)

5. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #010.

On September 22, 2015 at 0900hrs, Inspector #603 observed resident #010's bed with one half bed rail engaged on the right side of the bed and one half bed rail in the upper position (not engaged) on the left side of the bed. Inspector #603 interviewed resident #010 who explained that they have one bed rail engaged in order not to fall off their bed.

On September 23, 2015, Inspector interviewed RPN #110 who explained that the resident required the right bed rail to be engaged due to specific reasons. The resident had a safety device on the left side of the bed and a bed alarm for when the resident attempted to climb out of bed.

On September 23, 2015, Inspector interviewed PSW #120 and PSW #121 who explained that resident #010 required one half rail to be engaged on the right side of the bed. On the left side, the resident required one half rail to be in the up position to assist resident while moving in bed. The bed was positioned low and there was a safety device on the left side to prevent injury. PSWs #120 and #121 explained that these interventions would be in the care plan under safety and all staff had access to the care plan on their working tablet. PSWs #120 and #121 explained that the resident's bed rails were considered PASDs and not restraints.

Inspector reviewed the resident's care plan and there was no focus for bed rails, PASD, or restraints, nor was there direction on which side of the bed, a safety device would be placed.

LTCHA, 2007 S.O. 2007, s. 6. (1) was issued previously as WN and VPC during Inspection #2015_391603_0025, a WN and CO during Inspection #2014_283544_0021, a WN and CO during Inspection #2014_140158_0003, a WN and CO during Inspection #2013_138151_0030, and a WN and CO during Inspection # 2012_140158_0015. The scope of this issue was widespread and the severity was determined to be minimal harm or potential for actual harm. (603)

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 :

Feb 05, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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 4 day of February 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MARIE LAFRAMBOISE - (A1)

Service Area Office /
Bureau régional de services : Sudbury