Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 25, Mar 23, 2015	2015_325568_0006	L-001827-15	Resident Quality Inspection

Licensee/Titulaire de permis

SAUGEEN VALLEY NURSING CENTER LTD
465 DUBLIN STREET MOUNT FOREST ON N0G 2L3

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

SAUGEEN VALLEY NURSING CENTER
465 DUBLIN STREET MOUNT FOREST ON N0G 2L3

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

DOROTHY GINTHER (568), JUNE OSBORN (105), SHARON PERRY (155)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 3, 4, 5, 6, 9, 10, 11, and 12, 2015

The following Critical Incident inspections were done concurrently with this inspection:
002143-15, 001940-15, 005927-14, 009435-14, 007666-14. A follow-up inspection (L-001713-14) was also completed with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Temporary Assistant Director of Care, Director of Nutrition and Environmental Services, Director of Recreation, Nursing Clerk, Registered Dietitian, 2 Registered Nurses, 4 Registered Practical Nurses, 17 Personal Support Workers, 2 Activation Aides, 1 Dietary Aide, 1 Cook, Resident Council representative, Family Council representative, Residents and Families.

The inspector(s) also conducted a tour of all resident areas and common areas; observed residents and care provided to them; observed meal service, medication passes, medication storage areas; reviewed health care records and plans of care for identified residents; reviewed policies and procedures of the home, minutes from meetings and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **4 VPC(s)**
- **5 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 17. (1)	CO #003	2014_271532_0010	155
O.Reg 79/10 s. 72. (2)	CO #004	2014_271532_0010	105

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The Fall Prevention and Management Policy, Number NUM-B-820, Subject: Falls Prevention and Management: Assessment and Management Protocol, Effective Date: February 25, 2014; indicates in Part A: Fall Prevention,

The Registered Staff will:
Complete the Fall Risk Assessment (Morse Fall Scale PCC, Appendix A);
a. Within 24 hours of admission
b. Quarterly, if "Fall" RAP is triggered (as a secondary assessment)
c. After identification of significant change in status/condition

Document the level of fall risk on the resident's care plan.

a) A medical record review revealed the following:
A Fall Risk Assessment was completed on admission which indicated that an identified resident was a high risk for falls. There were no further Fall Risk Assessments completed. In 2014 a Resident Assessment Protocol(RAP) for falls triggered from the Minimum Data Set (MDS) assessment.

The care plan completed after the identified resident was assessed as being at high risk for falls did not include any notation of fall risk. Care plans completed in the following quarters and the current plan did not include the level of fall risk for the identified resident.

b) A Fall Risk Assessment was completed for an identified resident on admission which indicated that the resident was a Moderate Risk for falls. There were no further Fall Risk Assessments completed. Fall RAPS were triggered from MDS assessments in 2014.

The Registered Nurse verified that there had been no Fall Risk Assessments completed since admission for the identified residents and confirmed that the home's policy for Fall Prevention and Management had not been followed.

c) A Critical Incident was submitted by Saugeen Valley Nursing Center for an incident in which an identified resident was injured and admitted to hospital.

Clinical record review revealed that the Falls RAP was triggered by the Minimum Data Set (MDS) assessment in 2013 and 2014 for this resident. The falls RAP indicates that falls would be addressed in the care plan.

Record review revealed that the identified resident had a Fall Risk Assessment completed on admission. At that time the resident was identified as being a low risk for falls. No other risk assessments had been completed for the resident since admission.

Interview with the temporary Assistant Director of Care (ADOC) revealed that staff are expected to complete a Falls Risk Assessment on admission, quarterly - if high risk or triggered RAP, and with any significant change. The temporary ADOC acknowledged that the identified resident did not have a Fall Risk Assessment completed since admission despite the Falls RAP being triggered and significant changes in the residents' status. They confirmed that the home's Falls Prevention Program policy had not been complied with. (568)

d) The home's policy entitled Responsive Behavior Management, NUM-B-180, Part B: Interventions, outlines the following:

The Registered Staff will:
Upon occurrence of an episode of Responsive Behavior, the following interventions will be implemented / trialed and evaluated for effectiveness.
1. Registered Staff will initiate a STOP post-behavior huddle. Ensure that all required information has been collected and documented.
2. Make a referral to the in-house BSO team, by documenting under the 'BSO Referral' progress note.

All interventions will be implemented on the individual resident's Care Plan, as a Responsive Behavior Focus. The Care Plan focus will dictate the level of Behavioral Risk, based on initial assessment. In addition, the Care Plan will outline the risk factors for Responsive Behaviors. Specific goals will be outlined, and time lines for re-evaluation will be provided. Interventions will be documented and communicated to all staff.

Clinical record review revealed that an identified resident had a history of responsive behaviors which impacted both staff and other residents.

Interview with registered staff revealed that when an incident occurs where a resident exhibits responsive behaviors the registered staff will lead a behavior huddle with staff on the floor to review the incident, potential triggers and strategies to manage the behaviors. Following the huddle, they will complete a STOP Behavior Huddle form. These forms are kept on the residents chart. If the registered staff feels the resident would benefit from involvement of the Behavioral Supports Ontario(BSO) team in the home, they will complete a referral.

The Director of Care indicated that residents who exhibit responsive behaviors will have a care plan with this focus which outlines the potential triggers for these behaviors as well as strategies and interventions to reduce the risk of these behaviors. This care plan is used to provide direction to front line care staff.

Staff interview and record review confirmed that the identified resident was not being followed by the home's BSO team, there were no completed STOP Behavior Huddle forms, and there was no care plan with a focus of responsive behaviors that identified potential triggers and outlined strategies to assist staff in dealing with these behaviors.

The home's policy for Responsive Behavior Management was not complied with. (568) [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

WN #2: 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 failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

During the period of February 3-6, 2015 seven residents were observed to have a bed rail in the up position and their mattresses easily slid laterally on the bed system causing potential zones of entrapment.

On February 11, 2015 the Administrator confirmed that there were potential zones of entrapment for the seven identified residents. [s. 15. (1) (b)]

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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Record review revealed that an identified resident had an area of altered skin integrity. The area of altered skin integrity worsened over the next six weeks. At that time records identified a second area of altered skin integrity.

A Registered Nurse verified that the identified resident had two areas of altered skin integrity. The temporary Assistant Director of Care confirmed that the resident had not had an assessment of their altered skin integrity by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds:
has been assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented.

Record review revealed that an identified resident had an area of altered skin integrity. The area of altered skin integrity worsened over the next six weeks. At that time records identified a second area of altered skin integrity.

A Registered Nurse verified that the identified resident had two areas of altered skin integrity. Interview and record review confirmed that there had been no referral to the registered dietitian who is a member of the staff of the home. The Registered Dietitian verified that they were not advised that the identified resident had skin breakdown, and therefore the resident had not been assessed by the Registered Dietitian. [s. 50. (2) (b) (iii)]

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

a) Record review for an identified resident revealed that the resident had an area of altered skin integrity that was deteriorating. One week later documentation indicated that the altered skin integrity had worsened. There were no further weekly skin assessments done for the next seven weeks.

Review of Saugeen Valley Nursing Center Policy Number NUM-B-1540 entitled Skin Care-Wound Care Standards with effective date of January 21, 2009 states that any stage 2 or greater wound is to have an initial wound assessment completed and then weekly follow up on the Wound/Skin Assessment and Observation Tool. The Temporary Assistant Director of Care confirmed that the identified resident did not have their altered skin integrity reassessed at least weekly by a member of the registered nursing staff and acknowledged that the home's Skin Care-Wound Care Standards policy was not followed.

b) Review of an identified residents' clinical record revealed that they had an area of altered skin integrity. The area if altered skin integrity worsened over the next six weeks. At that time documentation identified a second area of altered skin integrity.

The Temporary Assistant Director of Care confirmed that there were no weekly skin assessments completed for the identified resident for a period of seven weeks. [s. 50. (2) (b) (iv)]

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. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that, for a resident demonstrating responsive behaviors,
(a) the behavioral triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviors, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

A Critical Incident was submitted by Saugeen Valley Nursing Center for an incident of alleged resident to resident abuse. Staff interview and record review revealed that an identified resident involved in this incident had a history of responsive behaviors directed at both staff and other residents.

Registered staff acknowledged that the identified residents' behaviors had been escalating and this had been reported to the physician. Interventions had been implemented in order to try to manage these behaviors.

The Director of Care revealed that it is the home's expectation that resident's exhibiting responsive behaviors would have a care plan which identifies potential triggers and provides strategies to assist staff when dealing with the identified behaviors. In addition, residents exhibiting a pattern of responsive behaviors may be referred to the home's BSO team, and following their assessment additional strategies may be identified on the resident's care plan or BSO toolbox.

The Director of Care confirmed that the identified resident had not been referred to the home's BSO team; and there was no care plan for responsive behaviors which identified potential triggers and outlined strategies / interventions to be used to manage these behaviors. [s. 53. (4)]

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. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

1. During the inspection a Registered Nurse was observed providing a treatment to one of the residents' in the lounge. There was a drop of blood noted on the floor and the surface where the dressing was being changed was unclean.

Interview with the Director of Care revealed that for both privacy and infection control reasons dressings should be changed in the residents' room. The Director of Care confirmed that the registered staff did not follow the homes infection prevention and control program when changing the identified residents' dressing.

2. During stage 1 observations of the inspection, three orange topped specimen bottles were found in the drawer of a three tier cart in one of the spa rooms. These specimen bottles contained a brown liquid. Only two of the three bottle identified residents. There was no information on the bottles that identified what the brown liquid was, what or how it was to be used, and no date as to when it was placed in this bottle.

The Director of Care was present and when asked what the liquid was she stated it was probably betadine. The Director of Care confirmed that the betadine should be kept in the original container, labeled with resident name and dated when opened. The Director of Care also acknowledged that this practice was not a good implementation of the infection prevention and control program.

3. During the inspection material call bell cords were observed to be soiled and stained in the washrooms adjoining seven resident rooms. The call bell cord in one room had a piece of ribbon attached to one end of the cord which was also stained and soiled.

Staff interview with the Director of Nutrition & Environmental Services revealed that housekeeping staff are responsible for cleaning the call bell cords in resident rooms, washrooms and common areas of the home. Housekeeping staff are instructed to wipe

down the cords with Precept. In terms of changing the cords when they become soiled the Director of Nutrition and Environmental Services indicated that the home does not have a process in place for this. They confirmed that the call bell cords in the resident washrooms identified were stained and soiled and that this was not in keeping with the home's infection control program. (568)

4. During the inspection a Registered Nurse was observed to enter one of the lounges and advise a resident that their dressing needed to be changed. The staff member did not ask the resident if they wished to go back to their room nor did they offer an alternative place to have their dressing changed. There were a number of other residents in the lounge at the time as it was approaching the lunch hour.

The Registered Nurse (RN), proceeded to provide treatment in the lounge. During the procedure discarded treatments and new treatments were handled by the RN, placed on the floor, and completed without implementing the home's infection prevention and control program.

Interview with the Director of Care revealed that for both privacy and infection control reasons treatments should be carried out in the residents' room. In addition, items being used for treatments should not have been placed directly on the floor. The Director of Care acknowledged that the registered staff did not follow the homes infection prevention and control program when changing the identified residents' dressing. (568) [s. 229. (4)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

a) During the inspection a Registered Nurse was observed to enter the lounge and advise resident #44 that their treatment needed to be completed. The staff member did not ask the resident if they wished to go back to their room nor did they offer them an alternative place to have their treatment. There were a number of other residents in the lounge at the time as it was approaching the lunch hour. The RN was then observed providing treatment to the identified resident.(568)

b) During the inspection a Registered Nurse was observed providing treatment to resident #054 in the lounge. Other residents and visitors were observed in the lounge at the same time. (155)

During a staff interview with the Director of Care it was revealed that treatments should be done in the privacy of a residents room, unless they request another location. The Director of Care confirmed that it is not the home's practice to conduct treatments in the lounge, particularly when other residents and visitors are present. They acknowledged that the identified residents right to be afforded privacy in treatment and in caring for their personal needs was not fully respected and promoted. ([s. 3. (1) 8.]

2. The licensee of the long-term care home failed to ensure that the rights of residents are fully respected and promoted in that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with the Act.

During observation of medication administration it was noted that medication strip packages that included the resident's name, room number and medications were being disposed of in the regular garbage while still legible. The Registered Practical Nurse confirmed that the medication strip packages were placed in the garbage on the medication cart that goes in the regular garbage disposal.

Interview with the Director of Care confirmed that the medication strip packages were being disposed of in the regular garbage. The Director of Care acknowledged that the residents right to 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 was not fully respected and promoted. [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 to 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.
11.(iv) Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with the Act., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

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

The Minimum Data Set (MDS) for an identified resident indicated that the resident requires extensive assistance of two persons for transfers. Modes of transfer include the

use of bed rails and mechanical lift.

Interview with the Director of Care revealed that it is the home's expectation that transfers would be addressed on the care plan in terms of the level of assistance, number of staff and equipment required. The Director of Care indicated that care staff take their direction for activities of daily living including transfers and bed mobility from the Kardex.

Record review and staff interview verified that there was no care plan related to transfers for the identified resident. [s. 6. (1) (a)]

2. The licensee has failed to ensure that that the plan of care is based on an assessment of the resident and the resident's needs and preferences.

Review of an identified residents' clinical record revealed that the plan of care did not indicate that the resident had altered skin integrity or pain. In addition, the plan of care did not identify the resident's needs with regards to interventions related to prevention of further skin breakdown nor did it identify any interventions to address the resident's needs for pain management related to skin breakdown.

During an interview with the identified resident they expressed that they had altered skin integrity, however there was no interventions in place to prevent further skin breakdown. The following day interventions were implemented.

The Temporary Assistant Director of Care confirmed that the plan of care for the identified resident did not indicate that the resident had skin breakdown nor did it identify any measures to prevent further skin breakdown. The following day an air mattress was placed on the residents bed and a gel cushion was placed on top of the standard wheelchair cushion.

During an interview with the identified resident they reported experiencing pain related to the area of altered skin integrity. The resident reported that the pain they were experiencing was severe. The resident indicated that the pain was a 10. The inspector advised the Director of Care that the resident had expressed that they were in pain.

The Director of Care confirmed that the identified residents' plan of care did not identify that the resident had pain nor did it identify any measures to prevent or relieve pain. [s. 6. (2)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days upon receiving concerns and recommendations from the Residents' Council.

A review of the December 17, 2014 Residents' Council Meeting minutes revealed two concerns were brought forward. The first concern related to laundry, specifically that residents were receiving socks that were mismatched and not their own. Residents' Council asked that laundry look at all the socks and ensure that they are matched up accurately. The second concern identified that the carts in the main dining room were squeaky.

An interview with the Residents' Council Assistant (Programs Manager), revealed that concerns/complaints are provided to management via the meeting minutes and are addressed in a letter that is provided for the following meeting from the Administrator. The Residents' Council assistant confirmed this has been the home's practice for addressing concerns brought forward at Residents' Council.

There was no meeting in January related to an outbreak. The Residents' Council has not received a response in writing to the December concerns to date. This response will be provided at the planned February meeting. [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee responds in writing within 10 days upon receiving concerns and recommendations from the Residents' Council., to be implemented voluntarily.

WN #9: 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 failed to ensure that 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,
iv. that complies with manufacturer's instructions for the storage of the drugs.

a) During the initial tour of the home it was noted that there were prescription lotions kept in the spa rooms on second and third floor.

The Director of Care was shown 4 bottles of Ectosone scalp lotion that was being kept in the 3 tier cart next to the tub in the second floor spa. This three tier cart also contained shampoo, conditioner, Kleenex, nail clippers and other grooming supplies. It was also noted that three of the four bottles of Ectosone scalp lotion had expired.

The Director of Care confirmed that the prescription lotions were not stored in an area that is used exclusively for drugs and drug-related supplies, that is secure and locked, and that the lotions had expired. It was also noted that the Ectosone lotion for an identified resident that had been discontinued in June 2014 remained accessible for staff to administer.

b) During the inspection it was noted that prescription creams were being kept in the third floor nursing supply room. A prescription cream for an identified resident was found in the cupboard with an expiry date of December 2014. Registered staff confirmed that the cream was expired and that the room was not used exclusively for drugs and drug-related supplies.

c). During the inspection the door to a shared resident room was observed wide open. A medication cup containing medication was noted sitting on a small table in the room. Neither resident residing in that room was present as they had gone to the dining room for lunch; and there were no staff in the area.

Registered staff confirmed that the medication should not have been left unlocked and unattended. (568) [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies; that is secure and locked; and that complies with manufacturer's instructions for the storage of the drugs., to be implemented voluntarily.

Issued on this 6th day of April, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DOROTHY GINTHER (568), JUNE OSBORN (105), SHARON PERRY (155)
Inspection No. / No de l'inspection :	2015_325568_0006
Log No. / Registre no:	L-001827-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 25, Mar 23, 2015
Licensee / Titulaire de permis :	SAUGEEN VALLEY NURSING CENTER LTD 465 DUBLIN STREET, MOUNT FOREST, ON, N0G-2L3
LTC Home / Foyer de SLD :	SAUGEEN VALLEY NURSING CENTER 465 DUBLIN STREET, MOUNT FOREST, ON, N0G-2L3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CATE MACLEAN

To SAUGEEN VALLEY NURSING CENTER LTD, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (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 the home's policy for the Falls Prevention and Management Program, policy number NUM-B-820; and the Responsive Behavior Management Program, policy number NUM-B-180; is complied with.

Grounds / Motifs :

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

The Fall Prevention and Management Policy, Number NUM-B-820, Subject: Falls Prevention and Management: Assessment and Management Protocol, Effective Date: February 25, 2014; indicates in Part A: Fall Prevention,
The Registered Staff will:
Complete the Fall Risk Assessment (Morse Fall Scale PCC, Appendix A);
a. Within 24 hours of admission
b. Quarterly, if "Fall" RAP is triggered (as a secondary assessment)
c. After identification of significant change in status/condition
Document the level of fall risk on the resident's care plan.

a) A medical record review revealed the following:
A Fall Risk Assessment was completed on admission which indicated that an identified resident was at high risk for falls. There were no other Fall Risk Assessments completed. In 2014 a Resident Assessment Protocol (RAP) for falls triggered from the Minimum Data Set (MDS) assessment.

The care plan completed after the identified resident was assessed as being at high risk for falls did not include any notation of fall risk. Care plans completed in the following quarters and the current plan did not include the level of falls risk for the identified resident.

b) A Fall Risk Assessment was completed for an identified resident on admission which indicated that the resident was a moderate risk for falls. Record review did not reveal any other Fall Risk Assessments for the identified resident. Fall RAPS were triggered from MDS assessments in 2014.

The Registered Nurse verified that there had been no Fall Risk Assessments completed since admission for the identified residents and confirmed that the home's policy for Fall Prevention and Management had not been followed.

c) A Critical Incident was submitted by Saugeen Valley Nursing Center for an incident in which a resident was injured and admitted to hospital.

Clinical record review revealed that the Falls RAP was triggered by the Minimum Data Set (MDS) assessment in 2013 and 2014 for this resident. The falls RAP indicates that falls will be addressed in the care plan.

Record review revealed that the identified resident had a Fall Risk Assessment completed on admission. At that time the resident was identified as being a low risk for falls. No other risk assessments had been completed for the resident since admission.

Interview with the temporary Assistant Director of Care (ADOC) revealed that staff are expected to complete a Fall Risk Assessment on admission, quarterly - if high risk or triggered RAP, and with any significant change. The temporary ADOC acknowledged that the identified resident did not have a Fall Risk Assessment completed since admission despite the Falls RAP being triggered and significant changes in the residents' status. They confirmed that the home's Falls Prevention Program policy had not been complied with. (568)

d) The home's policy entitled Responsive Behavior Management, NUM-B-180, Part B: Interventions, outlines the following:

The Registered Staff will:

Upon occurrence of an episode of Responsive Behavior, the following interventions will be implemented / trailed and evaluated for effectiveness.
1. Registered Staff will initiate a STOP post-behavior huddle. Ensure that all required information has been collected and documented.
2. Make a referral to the in-house Behavioral Supports Ontario (BSO) team, by documenting under the 'BSO Referral' progress note.

All interventions will be implemented on the individual resident's Care Plan, as a Responsive Behavior Focus. The Care Plan focus will dictate the level of Behavioral Risk, based on initial assessment. In addition, the Care Plan will outline the risk factors for Responsive Behaviors. Specific goals will be outlined, and time-lines for re-evaluation will be provided. Interventions will be documented and communicated to all staff.

Clinical record review revealed that an identified resident had a history of responsive behaviors directed at both staff and other residents.

Interview with a registered staff revealed that when an incident occurs where a resident exhibits responsive behaviors the registered staff will lead a behavior huddle with staff on the floor to review the incident, potential triggers and strategies to manage the behaviors. Following the huddle, they will complete a STOP Behavior Huddle form. These forms are kept on the residents chart. If the registered staff feels the resident would benefit from involvement of the BSO team they will complete a referral.

The Director of Care indicated that residents who exhibit responsive behaviors will have a care plan with this focus which outlines the potential triggers for these behaviors as well as strategies and interventions to reduce risk for these behaviors. This care plan is used to provide direction to front line care staff.

Staff interview and record review confirmed that the identified resident was not being followed by the home's BSO team, there were no completed STOP Behavior Huddle forms, and there was no care plan with a focus of responsive behaviors that identified potential triggers and outlined strategies to assist staff in dealing with these behaviors.

The home's policy for Responsive Behavior Management was not complied with. (568)
(105)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2015

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2014_271532_0010, CO #001;

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 steps are taken to prevent resident #07, #10, #11, #19, #33, #37 and any other resident from entrapment, taking into consideration all potential zones of entrapment.

Grounds / Motifs :

1. The licensee has failed to ensure that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment

During the period of February 3 to 6, 2015 seven residents were observed to have a bed rail in the up position and their mattresses easily slid laterally on the bed system causing potential zones of entrapment.

On February 11, 2015 the Administrator confirmed that there were potential zones of entrapment for the seven identified residents .

The licensee has failed to comply with order #001 from inspection # 2014_271532_0010 served On June 3, 2014.
(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall ensure that Resident #08, #20, any other resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, (iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and (iv) is reassessed at least weekly by a member of the registered nursing staff.

Grounds / Motifs :

1. The licensee has failed to ensure that that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Record review revealed that an identified resident had an area of altered skin integrity. The altered skin integrity deteriorated over the next six weeks. At that time records identified a second area of altered skin integrity.

A Registered Nurse (RN) verified that the identified resident had two areas of altered skin integrity. The temporary Assistant Director of Care confirmed that the resident had not had an assessment of their altered skin integrity by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. (155)

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds: has been assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the plan of care related to nutrition and hydration are implemented.

Record review revealed that an identified resident had an area of altered skin integrity. The altered skin integrity deteriorated over the next six weeks. At that time records identified a second area of altered skin integrity.

A Registered Nurse verified that the identified resident had two areas of altered skin integrity. Record review revealed that there had been no referral to the registered dietitian who is a member of the staff of the home. This was

confirmed by the temporary Assistant Director of Care.

Interview with the Registered Dietitian confirmed that they were not advised that the identified resident had skin breakdown, and therefore the resident had not been assessed by the Registered Dietitian.
(155)

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

a) Record review for an identified resident revealed that the resident had an area of altered skin integrity and it's status was deteriorating. One week later documentation indicated that the area of altered skin integrity had worsened. There were no further weekly skin assessments completed for the next seven weeks.

Review of Saugeen Valley Nursing Center Policy Number NUM-B-1540 entitled Skin Care-Wound Care Standards with effective date of January 21, 2009 states that any stage 2 or greater wound is to have an initial wound assessment completed and then weekly follow up on the Wound/Skin Assessment and Observation Tool.

The Temporary Assistant Director of Care confirmed that the identified resident did not have their altered skin integrity reassessed at least weekly by a member of the registered nursing staff and acknowledged that the home's Skin Care-Wound Care Standards policy was not followed.

b) Review of an identified residents' clinical record revealed that they had an area of altered skin integrity. The altered skin integrity deteriorated over the next six weeks. At that time documentation identified a second area of altered skin integrity.

The Temporary Assistant Director of Care confirmed that there were no weekly skin assessments done for the identified resident for a period of seven weeks.
(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2015

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that Resident #43 and any other resident demonstrating responsive behaviors has, (a) the behavioral triggers for the resident identified; (b) strategies developed and implemented to respond to these behaviors; and (c) actions taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to the interventions are documented.

Grounds / Motifs :

1. The licensee failed to ensure that, for a resident demonstrating responsive behaviors,
(a) the behavioral triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviors, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

A Critical Incident was submitted by Saugeen Valley Nursing Center for an incident of alleged resident to resident abuse.

Staff interview and record review revealed that an identified resident involved in this incident had a history of responsive behaviors directed at both staff and other residents.

Registered staff acknowledged that the identified residents' behaviors had been escalating and this had been reported to the physician. Interventions had been implemented in order to try to manage these behaviors.

The Director of Care revealed that it is the home's expectation that resident's exhibiting responsive behaviors would have a care plan which identifies potential triggers and provides strategies to assist staff when dealing with the identified behaviors. In addition, residents exhibiting a pattern of responsive behaviors may be referred to the home's Behavior Support Ontario (BSO) team, and following their assessment additional strategies may be identified on the resident's care plan or BSO toolbox.

The Director of Care confirmed that the identified resident had not been referred to the home's Behavioral Support team; and there was no plan of care for responsive behaviors which identified potential triggers and outlined strategies / interventions to be used to manage these behaviors. (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2015

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all staff participate in the implementation of the infection prevention and control program.

Grounds / Motifs :

1. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program.

a) During stage 1 observations of the inspection, three orange topped specimen bottles were found in the drawer of a three tier cart in one of the spa rooms. These specimen bottles contained a brown liquid. Only two of the three bottles identified residents. There was no information on the bottles that identified what the brown liquid was, what or how it was to be used, and no date as to when it was placed in this bottle.

The Director of Care was present and when asked what the liquid was they stated it was probably betadine. The Director of Care confirmed that the betadine should be kept in the original container, labeled with resident name and dated when opened. They also acknowledged that this practice was not a good implementation of the infection prevention and control program.

b) During the inspection a Registered Nurse was observed to enter one of the home's lounges and advise a resident that their dressing needed to be changed. The staff member did not ask the resident if they wished to go back to her room, nor did they offer an alternative place to have their treatment. There were a number of other residents in the lounge at the time as it was approaching the lunch hour.

The Registered Nurse (RN) proceeded to provide the treatment in the lounge.

During the procedure discarded treatments and new treatments were handled by the RN, placed on the floor, and completed without implementing the home's infection prevention and control program.

Interview with the Director of Care revealed that for both privacy and infection control reasons treatments should be provided in a residents' room. In addition, items being used for treatments should not be placed directly on the floor. The Director of Care acknowledged that the registered staff did not follow the homes' infection prevention and control program when changing the identified residents' dressing. (#568)

c) During the inspection a Registered Nurse was observed providing a treatment to a resident in one of the home's lounges. There was a drop of blood noted on the floor and the surface where the dressing was being changed was unclean.

Interview with the Director of Care revealed that for both privacy and infection control reasons treatments should be provided in the privacy of a residents' rooms. The Director of Care confirmed that the registered staff did not follow the homes infection prevention and control program when changing the identified residents' dressing.

d) During the inspection material call bell cords were observed to be soiled and stained in the washrooms adjoining seven resident rooms. The call bell cord in one room had a piece of ribbon attached to one end of the cord which was also stained and soiled.

Staff interview with the Direction of Nutrition & Environmental Services revealed that housekeeping staff are responsible for cleaning the call bell cords in resident rooms, washrooms and common areas of the home. Housekeeping staff are instructed to wipe down the cords with Precept. In terms of changing the cords when they become soiled, the Director of Nutrition and Environmental Services indicated that the home does not have a process in place for this. The Director confirmed that the call bell cords in the resident washrooms identified were stained and soiled and that this did not comply with the home's infection prevention and control program. (#568)
(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 25th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Dorothy Ginther

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