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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 1, 2014	2014_246196_0001	S-000005-14	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE
70 Spine Road, ELLIOT LAKE, ON, P5A-1X2

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

ST. JOSEPH'S MANOR
70 SPINE ROAD, ELLIOT LAKE, ON, P5A-1X2

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

LAUREN TENHUNEN (196), JENNIFER LAURICELLA (542), MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 21, 22, 23, 27, 28, 29, 30, 31, 2014

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Human Resources staff member, Dietary Manager, Registered Dietitian (RD), residents and family members.

During the course of the inspection, the inspector(s) conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed the health care records for several residents, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Admission Process
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

Findings/Faits saillants :

1. The care plan for resident #703 was reviewed by the inspector. The focus of "restraints" and "bed mobility" identified the use of a seat belt in wheelchair and full bed rails for safety but does not set out clear directions to staff and others who provide direct care to the resident, specifically the monitoring requirements.

The licensee failed to ensure that there is a written plan of care for resident #703 that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. In January 2014, resident #699 told the inspector that they do not like to have Saturday as one of their bath days. Resident #699 reported that their previous baths days were Tuesdays and Fridays and then it was changed to Wednesdays and Saturdays. The resident also told the inspector that they had "told the boss" that they would prefer a different bath day than Saturday. Resident #699's plan of care was reviewed and it was found that the resident's bath days are recorded as Wednesday and Saturday.

The Licensee failed to ensure that resident #699, was given an opportunity to participate fully in the development and implementation of their plan of care. [s. 6. (5)]

3. On a particular day in January 2014, the inspector observed the provision of afternoon nourishment on one of the units. Staff member #102 stated to the inspector that there was no Ensure pudding on the cart for resident #732 and #400. The inspector spoke to the Administrator/DOC and asked where the Ensure pudding would be stored as the PSW handing out the nourishment did not have this available on the cart for the residents that were to get it. The Administrator/DOC brought this inspector to both of the fridges on the unit, and it was identified that there was no Ensure pudding. The inspector reviewed the current plan of care for resident #732 and #400 and confirmed that they were both to receive the Ensure pudding during the afternoon nourishment, however on this particular day in January 2014 it was not provided.

The licensee failed to ensure that the care set out in the plan of care is provided to resident #732 and #400, as specified in the plan, specifically regarding the provision of afternoon nourishments. [s. 6. (7)]

4. On a particular day in January 2014, resident #703 was observed to have bruising. The health care records were reviewed and the care plan noted under the focus of "personal hygiene" the intervention of "assess skin for any open area or problems during care". There was no record of bruising in the resident's plan of care, including the progress notes, over the previous month to present. Staff member #101 then reported that the PSW's who provide baths and personal care are to assess the residents skin condition and report areas of concern to the registered staff where it would then be recorded in the progress notes.

The licensee failed to ensure that the care set out in the plan of care is provided to resident #703 as specified in the plan, specifically assessing skin condition during care. [s. 6. (7)]

5. On a particular evening in January 2014, inspectors observed resident #300 in the TV lounge/dining area watching television, with male and female co-residents. The inspectors observed the residents for five minutes in the TV lounge/dining area and during this time there were no staff members present until a staff member entered the area to take a co-resident to a different location.
Inspector #106 reviewed the progress notes for resident #300 for the time period between September 2013 through to the end of January 2014. Three separate entries indicated that resident #300 was found exhibiting inappropriate behaviour towards resident #745 and that resident #745 is cognitively unaware.

Resident #300's plan of care, specifically the current care plan document, was reviewed and it indicated that the resident was to be redirected to an activity in their room after mealtimes when staff were not present.

The Licensee failed to ensure that the care set out in the plan of care is provided to resident #300 as specified in the plan, specifically regarding responsive behaviours. [s. 6. (7)]

6. Compliance order #001 was previously issued on May 23, 2013 pursuant to LTCHA 2007,S.O.2007,c.8,s.6(7) Inspection #2013_139163_0012. [s. 6. (7)]

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. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(e) is approved by a registered dietitian who is a member of the staff of the home; O. Reg. 79/10, s. 71 (1).

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

Findings/Faits saillants :

1. During the course of inspection, in January 2014, the inspector spoke with the Registered Dietitian (RD) and was informed that in 2012 the home's menu cycle was approved with the recommendation that the daily fibre intake be increased to 21 grams/day. It was then reported that a flax seed cookie was added to the snack menu but this would only provide one gram of fibre per cookie and not all residents would be having this snack nor would they be able to have this type of food texture, therefore it would be inadequate. The RD also reported that the current menu cycle for 2013/2014 had not been reviewed or approved.

The licensee failed to ensure that the home's menu cycle is approved by a registered dietitian who is a member of the staff of the home. [s. 71. (1) (e)]

2. During the course of inspection, in January 2014, the inspector conducted an interview with the Registered Dietitian (RD). It was reported that the residents are not currently receiving enough fibre according to dietary requirements, and that without having standardized recipes for all menus it is very difficult to determine whether the residents are receiving enough nutrients and energy based on the current Dietary Reference Intakes (DRIs). The RD also stated that based on the calculations, the residents are lacking approximately 11 grams of fibre/day which was conveyed to the Food Service Manager. The RD reported to the inspector that the subsequent changes made to the fibre content of the menu, specifically the addition of a flax seed cookie to the snack menu, was not adequate to meet the nutrient requirements of the residents.

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

Additional Required Actions:

CO # - 002, 003 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. 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. In January 2014, inspector #542 reviewed home's policy NUM VI-70 "Continence Care." The home's policy indicated that the Registered Nursing Staff is to conduct a bowel and bladder continence assessment utilizing a clinically appropriate instrument on admission, quarterly and after any change in condition that may affect bladder or bowel continence. Inspector #196 reviewed resident #714's health care record and a continence assessment was not completed using a clinically appropriate instrument.

The licensee failed to ensure that where this Act or Regulation required the licensee of the Long-Term Care Home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy,protocol, procedure, strategy or system is complied with. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that where this Act or Regulation requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, specifically regarding continence care, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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. Resident #714 reported to inspector #196 during stage one of the inspection process, that a staff member had been verbally abusive towards them upon asking for assistance with toileting. According to the resident, the incident had been reported to management of the home and it had been dealt with. An interview was conducted with the Administrator/DOC and it was identified that the resident had reported this incident at the time of their annual care conference, that the identified staff members had been interviewed and the allegations could not be confirmed. The Administrator/DOC also confirmed that the incident of alleged verbal abuse was not reported to the Director. [s. 24. (1)]

2. Inspector #106 reviewed the progress notes for resident #300 for the time period between September 2013 through to the end of January 2014. Three separate entries indicated that resident #300 was exhibiting inappropriate behaviour towards resident #745 and that resident #745 is cognitively unaware. Inspector #106 discussed these entries with the Administrator/DOC and found that the home had conducted an investigation into these incidents and as a result, the plan of care for both residents was revised but the licensee did not inform the Director.

The Licensee failed to ensure that a person who has reasonable grounds to suspect that 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 a resident occurred or may occur immediately reported the suspicion and the information upon which it is based to the Director. [s. 24. (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 that ensures that a person who has reasonable grounds to suspect that 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 a resident occurred or may occur, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

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. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Findings/Faits saillants :

1. In January 2014, during an interview with the Administrator/DOC it was identified that the home did not have a written staffing plan for the nursing and personal support services program.

The licensee failed to ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b), specifically the nursing and personal support services programs. [s. 31. (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 that ensures that there is a written staffing plan for the nursing and personal support services programs, to be implemented voluntarily.

WN #6: 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. Resident #401 was identified in a Braden skin risk assessment, as high risk for skin breakdown. The health care records for resident #401 were reviewed and the Medication Administration Record (MAR) contained information for treatment of the wound and included a place for the registered staff to initial that the treatment was completed. The progress notes identified the dressing changes as they were done, but there were no weekly assessments documented.
A review of the resident's health care records were conducted by the inspector and registered staff member #104. A copy of "pressure ulcer/wound assessment record" was located and identified assessments were done in mid October, November and December 2013, and towards the end of January 2014. Weekly assessments of the wound were not completed as clinically indicated.

The licensee failed to ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures resident #401, who has exhibited altered skin integrity, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. During the course of inspection, resident #689 was observed to have a seat belt restraint in place while up in their wheelchair and full side rails when in bed. The "restraint observation form" for the month of January 2014 was reviewed and identified the use of full bed rails and a seat belt as types of restraints with the identified purpose of the restraints as being for safety. On two consecutive night shifts in January 2014, there was no documentation of the use of full bed rails and the monitoring of the use of the physical device. On seven different day shifts in January 2014, there was no documentation to identify the use of a seat belt restraint nor for the monitoring of the physical device. [s. 110. (7) 6.]

2. On a particular day in January 2014, staff member #105 told the inspector that the Medication Administration Record (MAR) are initialled by the registered staff members every twelve hours to acknowledge the use and effectiveness of the restraint device. The MAR sheet for the month of January 2014 for resident #689 was reviewed by the inspector and included the initials of registered staff for the day and night shifts, every twelve hours, not every eight hours as required. The reassessment of the restraint for resident #689, every eight hours by the registered staff was not documented. [s. 110. (7) 6.]

3. The MAR for January 2014 for resident #703 was reviewed for documentation of assessment by the registered staff regarding restraint use. The registered staff were not documenting the reassessment of resident #703's restraint every eight hours as required.

The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 6. All assessment, reassessment and monitoring, including the resident's response [s. 110. (7) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: all assessment, reassessment and monitoring, including the resident's response, to be implemented voluntarily.

WN #8: 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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. During the course of inspection, in January 2014, inspector #542 observed staff member #106 in the dining room on one of the units wearing a "surgical mask" and they stated that they had to wear it because they did not receive the Influenza vaccine. Upon observing this staff member, inspector #542 noted them lower the mask and touch it then proceeded to serve food to residents without any hand washing activities. On another day in January 2014, inspector #542 observed the same staff member #106 not wearing the "surgical mask" and when questioned, they stated, "oh I forgot to put it on."
On another day in January 2014, inspector #542 observed staff member #111 wearing a "surgical mask" improperly and frequently touching the mask while serving residents their meals and no hand washing was observed in between.

The licensee failed to ensure that all staff participate in the implementation of the program. [s. 229. (4)]

2. During the course of inspection, in January 2014, the inspector reviewed resident #201, 202 and #203's health care records and was unable to locate any documentation on whether a tetanus and diphtheria vaccine was offered or administered. Inspector #542 interviewed the Director of Care/Administrator, and was informed that they only began to offer the tetanus & diphtheria vaccine the previous week.

The licensee failed to ensure that residents are offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. [s. 229. (10) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that all staff participate in the implementation of the infection prevention and control program and ensures that resident #201, 202 and #203 are offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (4) During the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations. 2007, c. 8, s. 8 (4).

Findings/Faits saillants :

1. On two particular days in January 2014, it was reported to the inspector by the Administrator/DOC that they were acting as the charge RN in the home.

The licensee failed to ensure that during the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations. [s. 8. (4)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. During a walk through of the resident corridor, resident #402 asked the inspector for assistance to get out of bed. The inspector observed the call bell attached to the wall and the hand bell on the bedside table, out of reach of the resident.
Staff member #107 was questioned whether the resident had a Versus bell pinned to their clothing and it was determined the Versus bell was actually pinned to the wheelchair and also out of reach of the resident. Staff member #107 confirmed to the inspector that the resident should have had the call bell within reach.

The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times. [s. 17. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. During an interview, on a particular day in January 2014, resident #700 stated that sometimes their top and bottom teeth are sore. Inspector #542 reviewed the health care record for resident #700 and was unable to locate any annual oral/dental assessment for 2013. Inspector #542 interviewed Administrator/DOC and it was confirmed that no annual dental assessments and other preventive dental services are being offered to residents.

The licensee failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. [s. 34. (1) (c)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The most recent MDS quarterly assessment identified resident #714 as being occasionally incontinent of bowel and incontinent of bladder multiple times per day. An interview was conducted with staff member #108 and it was reported that resident #714 will call for assistance to toilet, is not cognitively impaired and is incontinent of bladder and occasionally of bowel and wears a brief at all times. The Administrator/DOC reviewed the online chart of resident #714 for a continence assessment and it was determined that it was not completed and it was reported to the inspector that the resident should have had an assessment done.

The licensee failed to ensure that, each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [s. 51. (2) (a)]

WN #13: 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. During an interview in January 2014, the Administrator/DOC informed the inspector that resident heights are completed on admission only and not done annually.

The licensee failed to ensure that the organized program of nutrition care and dietary services includes a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter. [s. 68. (2) (e)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. An interview was conducted by inspector #542 and #106 with the Registered Dietitian (RD) and it was reported that this home did not have standardized recipes for all menus. Inspector #542 met with the management staff member #109 and it was reported that "the cooks don't generally follow a recipe as they have been here for so long, they just do it according to their memory". Inspector #542 asked for standardized recipe for the "roast pork" that was on the menu for the following Saturday supper, and management staff member #109 stated that "they don't need to have a recipe for this as they know how to cook it". Inspector #542 reviewed the home's policy titled "food production" which stated, "the cooks and dietary aides shall follow standardized recipes to assure quality food production."

The licensee failed to ensure that the organized food production system in the home, must at a minimum, provide for standardized recipes and production sheets for all menus. [s. 72. (2) (c)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The inspector conducted a tour with the Administrator/DOC on January 29, 2014 and it was determined that the required information was not posted in the home in a conspicuous and easily accessible location. The contact information for the Director, copies of inspection reports and orders of the inspector were located in the foyer of the home where residents do not frequent this area unless entering or exiting the building. In addition, the home's policy to promote zero tolerance of abuse and neglect of residents, an explanation of the duty under section 24 to make mandatory reports, notification of the long-term care home's policy to minimize the restraining of residents and how to obtain a copy of the policy can be obtained, and an explanation of the protections afforded under section 26 were not posted in the home.

The licensee of a long-term care home failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. [s. 79. (1)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. During two separate interviews, the Residents' Council President and the Residents' Council Assistant, told the inspector that the licensee did not seek the advice of the Residents' Council's advice in the development and the carrying out of the satisfaction survey.

The Licensee failed to ensure that they sought the advice of the Residents' Council in developing and carrying out the satisfaction survey. [s. 85. (3)]

2. During an interview with a Family Council member, it was reported to inspector #106 that the Licensee had not sought the advice of the Family Council in developing and carrying out the satisfaction survey.

The Licensee failed to ensure that they sought the advice of the Family Council in developing and carrying out the satisfaction survey. [s. 85. (3)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. During the inspection, the Administrator/DOC gave a copy of Policy # NUM VII-7, "Zero Tolerance of Abuse and Neglect" to inspector #196. The inspector clarified with the Administrator/DOC that this was all of the home's abuse policies, and they indicated that it was. Inspector #106 reviewed the policy and found that, the home's written policy to promote zero tolerance of abuse and neglect of residents does not identify the training and retraining requirements for all staff specifically regarding training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations.

The Licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff specifically regarding training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations. [s. 96. (e)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. The medication cart on one of the units was observed, on a particular day in January 2014, to contain bottles of medications with resident #403's name handwritten on the lids. According to staff member #104, these three types of medications are brought in by a family member and are not provided by the home's pharmacy provider.
The inspector also observed five additional bottles of medications that were brought in by a family member for resident #404's use.

The licensee failed to ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug, (a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and (b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario [s. 122. (1)]

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 17. (1)	CO #001	2013_139163_0010	196
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #002	2013_139163_0012	196

Issued on this 7th day of April, 2014

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAUREN TENHUNEN (196), JENNIFER LAURICELLA (542), MARGOT BURNS-PROUTY (106)
Inspection No. / No de l'inspection :	2014_246196_0001
Log No. / Registre no:	S-000005-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 1, 2014
Licensee / Titulaire de permis :	ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE 70 Spine Road, ELLIOT LAKE, ON, P5A-1X2
LTC Home / Foyer de SLD :	ST. JOSEPH'S MANOR 70 SPINE ROAD, ELLIOT LAKE, ON, P5A-1X2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SUSAN CLAYTON

To ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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 ensure that the care set out in the plan of care is provided to residents #703, #300, #732 and #400 as specified in their plan.

Grounds / Motifs :

1. Compliance order #001 was previously issued on May 23, 2013 pursuant to LTCHA 2007,S.O.2007,c.8,s.6(7) Inspection # 2013_139163_0012.

(196)

2. On a particular evening in January 2014, inspectors observed resident #300 in the TV lounge /dining area watching television, with male and female co-residents. Inspectors observed the residents for five minutes in the TV lounge /dining area and during this time there were no staff members present until a staff member entered to take a co-resident to a different location.
Inspector #106 reviewed the progress notes for resident #300 for the time period between September 2013 through to the end of January 2014. Three separate entries indicated that resident #300 was found exhibiting inappropriate behaviour towards resident #745 and that resident #745 is cognitively unaware.

Resident #300's plan of care, specifically the current care plan document, was reviewed and it indicated that the resident was to be redirected to an activity in their room after mealtimes when staff were not present.

The Licensee failed to ensure that the care set out in the plan of care is provided to resident #300 as specified in the plan, specifically regarding responsive behaviours. (106)

3. On a particular day in January 2014, resident #703 was observed to have bruising. The health care records were reviewed and the care plan noted under the focus of "personal hygiene" the intervention of "assess skin for any open area or problems during care". There was no record of bruising in the resident's plan of care, including the progress notes, over the previous month to present. Staff member #101 then reported that the PSW's who provide baths and personal care are to assess the residents skin condition and report areas of concern to the registered staff where it would then be recorded in the progress notes.

The licensee failed to ensure that the care set out in the plan of care is provided to resident #703 as specified in the plan, specifically assessing skin condition during care. (196)

4. On a particular day in January 2014, the inspector observed the provision of afternoon nourishment on one of the units. Staff member #102 stated to the inspector that there was no Ensure pudding on the cart for resident #732 and #400. The inspector spoke with the Administrator/DOC and asked where the Ensure pudding would be stored as the PSW handing out the nourishment did not have this available on the cart for the residents that were to receive it. The Administrator/DOC brought this inspector to both of the fridges on the unit, and it was identified that there was no Ensure pudding. The inspector reviewed the current plan of care for resident #732 and #400 and confirmed that they were both to receive the Ensure pudding during the afternoon nourishment, however on this particular day in January 2014 it was not provided.

The licensee failed to ensure that the care set out in the plan of care is provided to resident #732 and #400 as specified in the plan, specifically regarding the provision of afternoon nourishments.

(542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 14, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(a) is a minimum of 21 days in duration;
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks;
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner;
(d) includes alternative beverage choices at meals and snacks;
(e) is approved by a registered dietitian who is a member of the staff of the home;
(f) is reviewed by the Residents' Council for the home; and
(g) is reviewed and updated at least annually. O. Reg. 79/10, s. 71 (1).

Order / Ordre :

The licensee shall ensure that the home's menu cycle, is approved by a registered dietitian who is a member of the staff of the home and is reviewed and updated at least annually.

Grounds / Motifs :

1. During the course of inspection, in January 2014, the inspector spoke with the Registered Dietitian (RD) and was informed that in 2012 the home's menu cycle was approved with the recommendation that the daily fibre intake be increased to 21 grams/day. It was then reported that a flax seed cookie was added to the snack menu but this would only provide one gram of fibre per cookie and not all residents would be having this snack nor would they be able to have this type of food texture, therefore it would be inadequate. The RD also reported that the current menu cycle for 2013/2014 had not been reviewed or approved.

The licensee failed to ensure that the home's menu cycle is approved by a registered dietitian who is a member of the staff of the home. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 16, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (2) The licensee shall ensure that each menu,
(a) provides for adequate nutrients, fibre and energy for the residents based on the current Dietary Reference Intakes (DRIs) established in the reports overseen by the United States National Academies and published by National Academy Press, as they may exist from time to time; and
(b) provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time. O. Reg. 79/10, s. 71 (2).

Order / Ordre :

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

Grounds / Motifs :

1. During the course of inspection, in January 2014, the inspector conducted an interview with the Registered Dietitian (RD). It was reported that the residents are not currently receiving enough fibre according to dietary requirements, and that without having standardized recipes for all menus it is very difficult to determine whether the residents are receiving enough nutrients and energy based on the current Dietary Reference Intakes (DRIs). The RD also stated that based on the calculations, the residents are lacking approximately 11 grams of fibre/day which was conveyed to the Food Service Manager. The RD reported to the inspector that the subsequent changes made to the fibre content of the menu, specifically the addition of a flax seed cookie to the snack menu, was not adequate to meet the nutrient requirements of the residents.

The licensee failed to ensure that each menu provides for adequate nutrients, fibre and energy for the residents based on the current Dietary Reference Intakes (DRIs) established in the reports overseen by the United States National Academies and published by the National Academy Press, as they may exist from time to time. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 16, 2014

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

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

and the Director

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 1st day of April, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lauren Tenhunen

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

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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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
Jun 06, 2014;	2014_246196_0001 (A1)	S-000005-14	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE
70 Spine Road, ELLIOT LAKE, ON, P5A-1X2

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

ST. JOSEPH'S MANOR
70 SPINE ROAD, ELLIOT LAKE, ON, P5A-1X2

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

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

LAUREN TENHUNEN (196) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance due dates for Order #002 and #003 were changed from June 16, 2014 to August 1, 2014 upon the licensee's request.

Issued on this 6 day of June 2014 (A1)

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

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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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
Jun 06, 2014;	2014_246196_0001 (A1)	S-000005-14	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE
70 Spine Road, ELLIOT LAKE, ON, P5A-1X2

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

ST. JOSEPH'S MANOR
70 SPINE ROAD, ELLIOT LAKE, ON, P5A-1X2

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

LAUREN TENHUNEN (196) - (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): January 21, 22, 23, 27, 28, 29, 30, 31, 2014

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Human Resources staff member, Dietary Manager, Registered Dietitian (RD), residents and family members.

During the course of the inspection, the inspector(s) conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed the health care records for several residents, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Admission Process

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Family Council

Food Quality

Infection Prevention and Control

Medication

Minimizing of Restraining

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Residents' Council

Responsive Behaviours

Skin and Wound Care

Snack Observation

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

Findings/Faits saillants :

1. The care plan for resident #703 was reviewed by the inspector. The focus of "restraints" and "bed mobility" identified the use of a seat belt in wheelchair and full bed rails for safety but does not set out clear directions to staff and others who provide direct care to the resident, specifically the monitoring requirements.

The licensee failed to ensure that there is a written plan of care for resident #703 that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. In January 2014, resident #699 told the inspector that they do not like to have Saturday as one of their bath days. Resident #699 reported that their previous baths days were Tuesdays and Fridays and then it was changed to Wednesdays and Saturdays. The resident also told the inspector that they had "told the boss" that they would prefer a different bath day than Saturday. Resident #699's plan of care was reviewed and it was found that the resident's bath days are recorded as Wednesday and Saturday.

The Licensee failed to ensure that resident #699, was given an opportunity to participate fully in the development and implementation of their plan of care. [s. 6. (5)]

3. On a particular day in January 2014, the inspector observed the provision of

afternoon nourishment on one of the units. Staff member #102 stated to the inspector that there was no Ensure pudding on the cart for resident #732 and #400. The inspector spoke to the Administrator/DOC and asked where the Ensure pudding would be stored as the PSW handing out the nourishment did not have this available on the cart for the residents that were to get it. The Administrator/DOC brought this inspector to both of the fridges on the unit, and it was identified that there was no Ensure pudding. The inspector reviewed the current plan of care for resident #732 and #400 and confirmed that they were both to receive the Ensure pudding during the afternoon nourishment, however on this particular day in January 2014 it was not provided.

The licensee failed to ensure that the care set out in the plan of care is provided to resident #732 and #400, as specified in the plan, specifically regarding the provision of afternoon nourishments. [s. 6. (7)]

4. On a particular day in January 2014, resident #703 was observed to have bruising. The health care records were reviewed and the care plan noted under the focus of "personal hygiene" the intervention of "assess skin for any open area or problems during care". There was no record of bruising in the resident's plan of care, including the progress notes, over the previous month to present. Staff member #101 then reported that the PSW's who provide baths and personal care are to assess the residents skin condition and report areas of concern to the registered staff where it would then be recorded in the progress notes.

The licensee failed to ensure that the care set out in the plan of care is provided to resident #703 as specified in the plan, specifically assessing skin condition during care. [s. 6. (7)]

5. On a particular evening in January 2014, inspectors observed resident #300 in the TV lounge/dining area watching television, with male and female co-residents. The inspectors observed the residents for five minutes in the TV lounge/dining area and during this time there were no staff members present until a staff member entered the area to take a co-resident to a different location.
Inspector #106 reviewed the progress notes for resident #300 for the time period between September 2013 through to the end of January 2014. Three separate entries indicated that resident #300 was found exhibiting inappropriate behaviour towards resident #745 and that resident #745 is cognitively unaware.

Resident #300's plan of care, specifically the current care plan document, was reviewed and it indicated that the resident was to be redirected to an activity in their

room after mealtimes when staff were not present.

The Licensee failed to ensure that the care set out in the plan of care is provided to resident #300 as specified in the plan, specifically regarding responsive behaviours. [s. 6. (7)]

6. Compliance order #001 was previously issued on May 23, 2013 pursuant to LTCHA 2007,S.O.2007,c.8,s.6(7) Inspection #2013_139163_0012. [s. 6. (7)]

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. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(e) is approved by a registered dietitian who is a member of the staff of the home; O. Reg. 79/10, s. 71 (1).

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

Findings/Faits saillants :

1. During the course of inspection, in January 2014, the inspector spoke with the Registered Dietitian (RD) and was informed that in 2012 the home's menu cycle was approved with the recommendation that the daily fibre intake be increased to 21 grams/day. It was then reported that a flax seed cookie was added to the snack menu but this would only provide one gram of fibre per cookie and not all residents would be having this snack nor would they be able to have this type of food texture, therefore it would be inadequate. The RD also reported that the current menu cycle for 2013/2014 had not been reviewed or approved.

The licensee failed to ensure that the home's menu cycle is approved by a registered dietitian who is a member of the staff of the home. [s. 71. (1) (e)]

2. During the course of inspection, in January 2014, the inspector conducted an interview with the Registered Dietitian (RD). It was reported that the residents are not currently receiving enough fibre according to dietary requirements, and that without having standardized recipes for all menus it is very difficult to determine whether the residents are receiving enough nutrients and energy based on the current Dietary Reference Intakes (DRIs). The RD also stated that based on the calculations, the residents are lacking approximately 11 grams of fibre/day which was conveyed to the Food Service Manager. The RD reported to the inspector that the subsequent changes made to the fibre content of the menu, specifically the addition of a flax seed cookie to the snack menu, was not adequate to meet the nutrient requirements of the residents.

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

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002,003

WN #3: 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. In January 2014, inspector #542 reviewed home's policy NUM VI-70 "Continence Care." The home's policy indicated that the Registered Nursing Staff is to conduct a bowel and bladder continence assessment utilizing a clinically appropriate instrument on admission, quarterly and after any change in condition that may affect bladder or bowel continence. Inspector #196 reviewed resident #714's health care record and a continence assessment was not completed using a clinically appropriate instrument.

The licensee failed to ensure that where this Act or Regulation required the licensee of the Long-Term Care Home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy,protocol, procedure, strategy or system is complied with. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that where this Act or Regulation requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, specifically regarding continence care, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #4: 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. Resident #714 reported to inspector #196 during stage one of the inspection process, that a staff member had been verbally abusive towards them upon asking for assistance with toileting. According to the resident, the incident had been reported to management of the home and it had been dealt with. An interview was conducted with the Administrator/DOC and it was identified that the resident had reported this incident at the time of their annual care conference, that the identified staff members had been interviewed and the allegations could not be confirmed. The Administrator/DOC also confirmed that the incident of alleged verbal abuse was not reported to the Director. [s. 24. (1)]

2. Inspector #106 reviewed the progress notes for resident #300 for the time period between September 2013 through to the end of January 2014. Three separate entries indicated that resident #300 was exhibiting inappropriate behaviour towards resident #745 and that resident #745 is cognitively unaware. Inspector #106 discussed these entries with the Administrator/DOC and found that the home had conducted an investigation into these incidents and as a result, the plan of care for both residents was revised but the licensee did not inform the Director.

The Licensee failed to ensure that a person who has reasonable grounds to suspect that 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 a resident occurred or may occur immediately reported the suspicion and the information upon which it is based to the Director. [s. 24. (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 that ensures that a person who has reasonable grounds to suspect that 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 a resident occurred or may occur, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

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. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Findings/Faits saillants :

1. In January 2014, during an interview with the Administrator/DOC it was identified that the home did not have a written staffing plan for the nursing and personal support services program.

The licensee failed to ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b), specifically the nursing and personal support services programs. [s. 31. (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 that ensures that there is a written staffing plan for the nursing and personal support services programs, to be implemented voluntarily.

WN #6: 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. Resident #401 was identified in a Braden skin risk assessment, as high risk for skin breakdown. The health care records for resident #401 were reviewed and the Medication Administration Record (MAR) contained information for treatment of the wound and included a place for the registered staff to initial that the treatment was completed. The progress notes identified the dressing changes as they were done, but there were no weekly assessments documented.
A review of the resident's health care records were conducted by the inspector and registered staff member #104. A copy of "pressure ulcer/wound assessment record" was located and identified assessments were done in mid October, November and December 2013, and towards the end of January 2014. Weekly assessments of the wound were not completed as clinically indicated.

The licensee failed to ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures resident #401, who has exhibited altered skin integrity, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. During the course of inspection, resident #689 was observed to have a seat belt restraint in place while up in their wheelchair and full side rails when in bed. The "restraint observation form" for the month of January 2014 was reviewed and identified the use of full bed rails and a seat belt as types of restraints with the identified purpose of the restraints as being for safety. On two consecutive night shifts in January 2014, there was no documentation of the use of full bed rails and the monitoring of the use of the physical device. On seven different day shifts in January 2014, there was no documentation to identify the use of a seat belt restraint nor for the monitoring of the physical device. [s. 110. (7) 6.]

2. On a particular day in January 2014, staff member #105 told the inspector that the Medication Administration Record (MAR) are initialled by the registered staff members every twelve hours to acknowledge the use and effectiveness of the restraint device. The MAR sheet for the month of January 2014 for resident #689 was reviewed by the inspector and included the initials of registered staff for the day and night shifts, every twelve hours, not every eight hours as required. The reassessment of the restraint for resident #689, every eight hours by the registered staff was not documented. [s. 110. (7) 6.]

3. The MAR for January 2014 for resident #703 was reviewed for documentation of assessment by the registered staff regarding restraint use. The registered staff were not documenting the reassessment of resident #703's restraint every eight hours as required.

The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 6. All assessment, reassessment and monitoring, including the resident's response [s. 110. (7) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: all assessment, reassessment and monitoring, including the resident's response, to be implemented voluntarily.

WN #8: 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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. During the course of inspection, in January 2014, inspector #542 observed staff member #106 in the dining room on one of the units wearing a "surgical mask" and they stated that they had to wear it because they did not receive the Influenza vaccine. Upon observing this staff member, inspector #542 noted them lower the mask and touch it then proceeded to serve food to residents without any hand washing activities. On another day in January 2014, inspector #542 observed the same staff member #106 not wearing the "surgical mask" and when questioned, they stated, "oh I forgot to put it on."
On another day in January 2014, inspector #542 observed staff member #111 wearing a "surgical mask" improperly and frequently touching the mask while serving residents their meals and no hand washing was observed in between.

The licensee failed to ensure that all staff participate in the implementation of the program. [s. 229. (4)]

2. During the course of inspection, in January 2014, the inspector reviewed resident #201, 202 and #203's health care records and was unable to locate any documentation on whether a tetanus and diphtheria vaccine was offered or administered. Inspector #542 interviewed the Director of Care/Administrator, and was informed that they only began to offer the tetanus & diphtheria vaccine the previous week.

The licensee failed to ensure that residents are offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. [s. 229. (10) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that all staff participate in the implementation of the infection prevention and control program and ensures that resident #201, 202 and #203 are offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (4) During the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations. 2007, c. 8, s. 8 (4).

Findings/Faits saillants :

1. On two particular days in January 2014, it was reported to the inspector by the Administrator/DOC that they were acting as the charge RN in the home.

The licensee failed to ensure that during the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations. [s. 8. (4)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. During a walk through of the resident corridor, resident #402 asked the inspector for assistance to get out of bed. The inspector observed the call bell attached to the wall and the hand bell on the bedside table, out of reach of the resident.
Staff member #107 was questioned whether the resident had a Versus bell pinned to their clothing and it was determined the Versus bell was actually pinned to the wheelchair and also out of reach of the resident. Staff member #107 confirmed to the inspector that the resident should have had the call bell within reach.

The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times. [s. 17. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. During an interview, on a particular day in January 2014, resident #700 stated that sometimes their top and bottom teeth are sore. Inspector #542 reviewed the health care record for resident #700 and was unable to locate any annual oral/dental assessment for 2013. Inspector #542 interviewed Administrator/DOC and it was confirmed that no annual dental assessments and other preventive dental services are being offered to residents.

The licensee failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. [s. 34. (1) (c)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The most recent MDS quarterly assessment identified resident #714 as being occasionally incontinent of bowel and incontinent of bladder multiple times per day. An interview was conducted with staff member #108 and it was reported that resident #714 will call for assistance to toilet, is not cognitively impaired and is incontinent of bladder and occasionally of bowel and wears a brief at all times. The Administrator/DOC reviewed the online chart of resident #714 for a continence assessment and it was determined that it was not completed and it was reported to the inspector that the resident should have had an assessment done.

The licensee failed to ensure that, each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [s. 51. (2) (a)]

WN #13: 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. During an interview in January 2014, the Administrator/DOC informed the inspector that resident heights are completed on admission only and not done annually.

The licensee failed to ensure that the organized program of nutrition care and dietary services includes a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter. [s. 68. (2) (e)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. An interview was conducted by inspector #542 and #106 with the Registered Dietitian (RD) and it was reported that this home did not have standardized recipes for all menus. Inspector #542 met with the management staff member #109 and it was reported that "the cooks don't generally follow a recipe as they have been here for so long, they just do it according to their memory". Inspector #542 asked for standardized recipe for the "roast pork" that was on the menu for the following Saturday supper, and management staff member #109 stated that "they don't need to have a recipe for this as they know how to cook it". Inspector #542 reviewed the home's policy titled "food production" which stated, "the cooks and dietary aides shall follow standardized recipes to assure quality food production."

The licensee failed to ensure that the organized food production system in the home, must at a minimum, provide for standardized recipes and production sheets for all menus. [s. 72. (2) (c)]

WN #15: The Licensee has failed to comply with LTCHA, 2007, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The inspector conducted a tour with the Administrator/DOC on January 29, 2014 and it was determined that the required information was not posted in the home in a conspicuous and easily accessible location. The contact information for the Director, copies of inspection reports and orders of the inspector were located in the foyer of the home where residents do not frequent this area unless entering or exiting the building. In addition, the home's policy to promote zero tolerance of abuse and neglect of residents, an explanation of the duty under section 24 to make mandatory reports, notification of the long-term care home's policy to minimize the restraining of residents and how to obtain a copy of the policy can be obtained, and an explanation of the protections afforded under section 26 were not posted in the home.

The licensee of a long-term care home failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. [s. 79. (1)]

WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. During two separate interviews, the Residents' Council President and the Residents' Council Assistant, told the inspector that the licensee did not seek the advice of the Residents' Council's advice in the development and the carrying out of the satisfaction survey.

The Licensee failed to ensure that they sought the advice of the Residents' Council in developing and carrying out the satisfaction survey. [s. 85. (3)]

2. During an interview with a Family Council member, it was reported to inspector #106 that the Licensee had not sought the advice of the Family Council in developing and carrying out the satisfaction survey.

The Licensee failed to ensure that they sought the advice of the Family Council in developing and carrying out the satisfaction survey. [s. 85. (3)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. During the inspection, the Administrator/DOC gave a copy of Policy # NUM VII-7, "Zero Tolerance of Abuse and Neglect" to inspector #196. The inspector clarified with the Administrator/DOC that this was all of the home's abuse policies, and they indicated that it was. Inspector #106 reviewed the policy and found that, the home's written policy to promote zero tolerance of abuse and neglect of residents does not identify the training and retraining requirements for all staff specifically regarding training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations.

The Licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff specifically regarding training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations. [s. 96. (e)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. The medication cart on one of the units was observed, on a particular day in January 2014, to contain bottles of medications with resident #403's name handwritten on the lids. According to staff member #104, these three types of medications are brought in by a family member and are not provided by the home's pharmacy provider.
The inspector also observed five additional bottles of medications that were brought in by a family member for resident #404's use.

The licensee failed to ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug, (a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and (b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario [s. 122. (1)]

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 17. (1)	CO #001	2013_139163_0010	196
LTCHA, 2007 s. 3. (1)	CO #002	2013_139163_0012	196

Issued on this 6 day of June 2014 (A1)

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

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
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LAUREN TENHUNEN (196) - (A1)

Inspection No. / No de l'inspection : 2014_246196_0001 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : S-000005-14 (A1)

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

Report Date(s) / Date(s) du Rapport : Jun 06, 2014;(A1)

Licensee / Titulaire de permis : ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE
70 Spine Road, ELLIOT LAKE, ON, P5A-1X2

LTC Home / Foyer de SLD : ST. JOSEPH'S MANOR
70 SPINE ROAD, ELLIOT LAKE, ON, P5A-1X2

Name of Administrator / Nom de l'administratrice ou de l'administrateur : SUSAN CLAYTON

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

To ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE, 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 :

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 ensure that the care set out in the plan of care is provided to residents #703, #300, #732 and #400 as specified in their plan.

Grounds / Motifs :

1. Compliance order #001 was previously issued on May 23, 2013 pursuant to LTCHA 2007,S.O.2007,c.8,s.6(7) Inspection # 2013_139163_0012.

(196)

2. On a particular evening in January 2014, inspectors observed resident #300 in the TV lounge /dining area watching television, with male and female co-residents. Inspectors observed the residents for five minutes in the TV lounge /dining area and during this time there were no staff members present until a staff member entered to take a co-resident to a different location.
Inspector #106 reviewed the progress notes for resident #300 for the time period between September 2013 through to the end of January 2014. Three separate entries indicated that resident #300 was found exhibiting inappropriate behaviour towards resident #745 and that resident #745 is cognitively unaware.

Resident #300's plan of care, specifically the current care plan document, was reviewed and it indicated that the resident was to be redirected to an activity in their room after mealtimes when staff were not present.

The Licensee failed to ensure that the care set out in the plan of care is provided to resident #300 as specified in the plan, specifically regarding responsive behaviours. (106)

3. On a particular day in January 2014, resident #703 was observed to have bruising. The health care records were reviewed and the care plan noted under the focus of "personal hygiene" the intervention of "assess skin for any open area or problems during care". There was no record of bruising in the resident's plan of care, including the progress notes, over the previous month to present. Staff member #101 then reported that the PSW's who provide baths and personal care are to assess the residents skin condition and report areas of concern to the registered staff where it would then be recorded in the progress notes.

The licensee failed to ensure that the care set out in the plan of care is provided to resident #703 as specified in the plan, specifically assessing skin condition during care. (196)

4. On a particular day in January 2014, the inspector observed the provision of afternoon nourishment on one of the units. Staff member #102 stated to the inspector that there was no Ensure pudding on the cart for resident #732 and #400. The inspector spoke with the Administrator/DOC and asked where the Ensure pudding would be stored as the PSW handing out the nourishment did not have this available on the cart for the residents that were to receive it. The Administrator/DOC brought this inspector to both of the fridges on the unit, and it was identified that there was no Ensure pudding. The inspector reviewed the current plan of care for resident #732 and #400 and confirmed that they were both to receive the Ensure pudding during the afternoon nourishment, however on this particular day in January 2014 it was not provided.

The licensee failed to ensure that the care set out in the plan of care is provided to resident #732 and #400 as specified in the plan, specifically regarding the provision of afternoon nourishments.

(542)

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

Apr 14, 2014

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(a) is a minimum of 21 days in duration;
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks;
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner;
(d) includes alternative beverage choices at meals and snacks;
(e) is approved by a registered dietitian who is a member of the staff of the home;
(f) is reviewed by the Residents' Council for the home; and
(g) is reviewed and updated at least annually. O. Reg. 79/10, s. 71 (1).

Order / Ordre :

The licensee shall ensure that the home's menu cycle, is approved by a registered dietitian who is a member of the staff of the home and is reviewed and updated at least annually.

Grounds / Motifs :

1. During the course of inspection, in January 2014, the inspector spoke with the Registered Dietitian (RD) and was informed that in 2012 the home's menu cycle was approved with the recommendation that the daily fibre intake be increased to 21 grams/day. It was then reported that a flax seed cookie was added to the snack menu but this would only provide one gram of fibre per cookie and not all residents would be having this snack nor would they be able to have this type of food texture, therefore it would be inadequate. The RD also reported that the current menu cycle for 2013/2014 had not been reviewed or approved.

The licensee failed to ensure that the home's menu cycle is approved by a registered dietitian who is a member of the staff of the home. (542)

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

Aug 01, 2014(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

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. 71. (2) The licensee shall ensure that each menu,
(a) provides for adequate nutrients, fibre and energy for the residents based on the current Dietary Reference Intakes (DRIs) established in the reports overseen by the United States National Academies and published by National Academy Press, as they may exist from time to time; and
(b) provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time. O. Reg. 79/10, s. 71 (2).

Order / Ordre :

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

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

Grounds / Motifs :

1. During the course of inspection, in January 2014, the inspector conducted an interview with the Registered Dietitian (RD). It was reported that the residents are not currently receiving enough fibre according to dietary requirements, and that without having standardized recipes for all menus it is very difficult to determine whether the residents are receiving enough nutrients and energy based on the current Dietary Reference Intakes (DRIs). The RD also stated that based on the calculations, the residents are lacking approximately 11 grams of fibre/day which was conveyed to the Food Service Manager. The RD reported to the inspector that the subsequent changes made to the fibre content of the menu, specifically the addition of a flax seed cookie to the snack menu, was not adequate to meet the nutrient requirements of the residents.

The licensee failed to ensure that each menu provides for adequate nutrients, fibre and energy for the residents based on the current Dietary Reference Intakes (DRIs) established in the reports overseen by the United States National Academies and published by the National Academy Press, as they may exist from time to time. (542)

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

Aug 01, 2014(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

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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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 6 day of June 2014 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LAUREN TENHUNEN - (A1)

Service Area Office / Bureau régional de services : Sudbury