Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 29, 2015	2015_331595_0003	S-000683-15	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

MARINA MOFFATT (595), JENNIFER LAURICELLA (542), VALA MONESTIME BELTER (580)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 9 - 13, 16 - 20, 2015

The following Ministry of Health and Long-Term Care (MOHLTC) logs were concurrently inspected: S-000621-14, S-000679-15, S-000647-15, S-000356-14, S-000328-14.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Administrative Assistant, Food Service Manager, IT Personnel, Housekeeping, Activity/Recreation Therapists and Aides, Dietary Aides, Dietary Assistant, Registered and Non-Registered Staff, Residents and Family Members.

Throughout the inspection, inspectors completed health care record reviews, observations, and review of the home's policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2014_336580_0018	580

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for resident #001 set out clear directions to staff and others who provide direct care to the resident.

Throughout the RQI, Inspectors #542, #580, #595 and #613 observed resident #001 in a specific location of the home upon their entrance and exit to the home each day, as well as various times throughout the day. Inspectors were in the home from February 9 - 13, 16 - 20, 2015.

Inspector #595 and #580 asked the Administrator/DOC if there was a process in place to monitor this resident while they were in this location as there was a risk for resident health and safety. The Administrator stated that this resident was on 30-minute checks by staff. They explained that staff on the resident's home area would have to go check on the resident.

On February 18, 2015, Inspector #595 spoke with s#-100 who stated that resident #001 was on strict 30-minute checks and that staff were to sign off on a flow sheet every 30 minutes and indicate where the resident was. It was noted that the flow sheets were signed off for this particular day. Inspector asked how staff would check on them while they were in this location. The staff stated that they would either look out a window or go to the resident to see them.

Inspector #595 reviewed resident #001's care plan on February 11, 2015. The care plan

did not identify that the resident was on 30-minute checks by staff and that staff were required to sign off on a flow sheet each check. [s. 6. (1) (c)]

2. The licensee failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to residents #032 and #039.

During the course of the inspection, Inspector #580 observed resident #032 seated in a wheelchair.

Inspector #580 spoke with s#-104 who stated that resident #032's wheelchair was tilted to relieve pressure. Another staff member, s#-105, stated that resident #032's wheelchair was tilted for comfort. Inspector also spoke with s#-106 who stated that they would tilt resident #032 if the resident asked, that they were not aware of any care plan direction about the tilt wheelchair.

Inspector #580 spoke with s#-101, s#-102, and s#-103 who confirmed that they get resident care information from the care plan. Inspector #580 reviewed resident #032's care plan which identified that the resident used a wheelchair from the home, however there was no indication that the resident used a tilt wheelchair.

Inspector #580 reviewed resident #039's health care record. Upon review of the care plan, it was noted that there was no direction or reference to the resident's bathing schedule. It was confirmed by s#-101, s#-102, and s#-103 that they get resident care information from the care plan.

Inspector #580 reviewed the home's bath list dated December 29, 2014, to February 1, 2015, for both resident home areas. The list included resident names, bath day schedule, and bath specifics including type of bath, lift required, and treatments to be completed. Inspector #580 could not locate resident #039 on either of the two bath lists in the home. [s. 6. (1) (c)]

3. The licensee failed to ensure that the care plan set out clear directions to staff and others who provide care to residents #031, #032, #033, #034, #035, #036, #037, #038, and #039.

Inspector #580 spoke with s#-101, s#-102, and s#-103 who confirmed that they get resident care information from the care plan.

On February 9, 2015, Inspector #580 observed a posted list (dated December 23, 2014) in the two dining room/serveries which identified fluid consistencies for residents of that home area. Inspector spoke with s#-108 who confirmed that the sheet was meant for Personal Support Workers (PSWs) to refer to during meal times to determine resident meal requirements and diet information. It was also identified by s#-108, s#-109, s#-110, and s#-111 that nursing staff and dietary aides use the Daily Resident List (DRL) for resident diet orders, food consistency information and preferences, but will look at the posted list as well for quick reference.

Inspector #580 spoke with s#-111 who stated that according to the DRL, resident #036 received thickened fluids at meals. Inspector also observed s#-112 mixing a thickner into a liquid for resident #036. Inspector reviewed the posted quick-reference sheet which did not identify that resident #036 required thickened fluids. S#-111 and s#-112 confirmed that the posted sheet did not contain resident #036's order for thickened fluids. Inspector #580 reviewed resident #036's care plan which identified that they were to receive thickened fluids.

Upon further review, Inspector #580 identified numerous inconsistencies between the DRL, the posted lists and resident care plans. They are as follows:

Resident #032:
- Care plan identified that the resident was to receive thin fluids and prune juice every second day; this was neither in the DRL or posted list. Additionally, the posted sheet did not identify the diet and texture as outlined in the DRL and care plan.

Resident #038:
- Care plan identified that the resident was to receive thin fluids; this was neither in the DRL or posted servery list. Additionally, the posted list did not identify the diet or texture as outlined in the DRL and care plan. The DRL also highlighted for staff to encourage fluid intake to 1500cc, however this was not in the care plan or posted list.

Resident #033:
- Care plan identified that the resident was to receive thin fluids; this was neither in the DRL or posted list. Additionally, the posted list did not identify the diet, texture, or to avoid a specific food as outlined in the DRL and care plan.

Resident #035:

- Care plan identified that the resident was to receive thin fluids; this was neither on the DRL or posted list. Additionally, the posted list did not identify the diet and texture as outlined in the DRL or care plan. The posted list and DRL also identified the use of an anti-slip mat, however this was not in the resident's care plan.

Resident #039:
- Care plan identified that the resident was to use a straw or sippy cup for fluids, however this was not in the posted list or DRL. The DRL also identified that the resident was to receive small portions, although this was not in the care plan or on the posted list. Additionally, the posted list did not identify the diet and texture as outlined in the DRL and care plan.

Resident #034:
- Care plan identified that the resident was to receive thin fluids; this was neither in the DRL or posted list. Additionally, the posted list did not identify the diet and texture as outlined in the DRL and care plan.

Resident #031:
- Care plan identified that the resident was to receive thin fluids; this was neither on the DRL or posted list. Additionally, the posted list did not identify the diet and texture as outlined in the DRL and care plan. The DRL identified the use of a rimmed plate and non-slip mat, the posted list identified the use of just an anti-slip mat, and the care plan did not identify either intervention.

Resident #037:
- Care plan identified that resident was to have a mechanically soft diet, however the DRL identified that a regular texture was to be provided, and the posted list had no texture identified. The DRL also identified that the resident was to have fluids limited to two liters per day, although this was neither in the care plan or posted list. Additionally, the care plan and posted list highlighted that the resident was to receive one scoop of protein powder at each meal, but was not listed on the DRL. [s. 6. (1) (c)]

4. The licensee failed to ensure that the resident, resident's substitute decision-maker (SDM), and any other persons designated by the resident or SDM are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Inspector #580 reviewed resident #039's health care record. It was identified in the

progress notes that the resident started a medication in December 2014. There was no progress note that indicated that the SDM was informed of the medication change. In a following progress note, a staff member told the SDM that the resident had started the medication about a week ago. The SDM requested to talk to the physician, and spoke further with the staff member of the medication change.

Inspector #580 reviewed an email from the Administrator/DOC to the prescribing physician. In the email it identified that the home did not phone the SDM when the medication was ordered, and that they would talk to staff about the importance of phoning SDMs for medication order changes.

On February 19, 2015 the Administrator/DOC confirmed to the inspector that the home did not advise resident #039's SDM of a new medication order until a week after it had been started. [s. 6. (5)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, specifically in regards to the Versus resident and staff communication and response system.

On February 17, 2015, Inspector #595 observed that the call bell in a resident room remained on from 1320h - 1350h. Throughout this time, one staff member, s#-118, passed by the room and did not check in or acknowledge the resident in the room. The door to the room was slightly ajar. Inspector #595 checked the call system computer at the nursing station, which did not identify that the resident's call system was activated. Inspector #613 interviewed four Personal Support Workers (PSWs) and asked if their pagers were going off. All stated that their pagers had not gone off. Inspector #595 spoke with s#-118 who stated that this resident's call bell was stuck and would not be fixed unless maintenance staff went in there. They also stated that the call bell was not registered on the computer or pagers as the call system had been shut off by the housekeeper.

Inspector #595 brought the information to the Administrative Assistant, s#-119, who rebooted the system and was able to fix the call bell temporarily. Inspector #595 asked s#-119 about the home's process for identifying and addressing call system problems. S#-119 stated that floor staff are to fill out a 'Repair Versus System/Pendants' form that identifies the problem and troubleshooting completed. The form is to be brought to s#-119 who would then further investigate the issue.

On February 18, 2015, Inspector #595 asked s#-119 if a 'Repair Versus System/Pendants' form was filled out for the call system malfunction that occurred the day prior, on February 17, 2015. They stated that no staff had filled out the report.

On February 18, 2015, Inspector #595 received a generated report from s#-119 of call bell response times. The report identified the time that a resident initiated a call and the time a staff member answered the call. It was identified by s#-119 that some of the times on the report were wrong, as the time the resident initiated the call was after the time a staff member answered the call. Inspector #595 spoke with s#-120 who stated that the error in the report was not an error due to the generation of the report, rather it was the system that was malfunctioning with incorrect times.

Later in the day, on February 18, 2015, Inspector #542 returned to the same resident room and observed the call bell on. Additionally, Inspector #542 observed that while s#-121 walked down the hall, resident lights were activated (they turned green which indicated that a staff member entered the room). The staff member confirmed that the lights should not be doing that and should only turn green when a staff member got close to the sensor inside the resident room. S#-121 said that the call bell to the resident room often gets stuck, and stated that another resident's call light "gets stuck" and remains on.

S#-121 also commented that it has happened where the entire call system shuts down, and in the case where s#-119 can't come in to fix it, the home has called in another PSW to walk the halls and check in on residents. S#-121 explained that sometimes staff will get 'phantom' calls, where the system picks up a call bell but either the resident did not initiate the bell or was not in their room to pull the bell. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents are not neglected by the licensee or staff.

Inspector #542 reviewed a Critical Incident (CI) report regarding an incident of staff-to-resident neglect that occurred in 2015. The CI indicated that resident #002 was found in their room at 2300h, sitting in their chair fully clothed, the door was closed and no lights were on.

The CI report described that staff members, s#-112, s#-132 and s#-133, working the evening shift did not provide resident #002 with evening care, was not transferred to bed and hourly checks were not performed. The RPN did not check on the resident as they do not receive medication at that time of the day. Shortly after evening shift was finished, the night shift PSW completed a round and found resident #002 sitting in their chair, fully dressed, in their room, in the dark with the door closed. The resident did not receive bedtime care and was not transferred back to bed. The resident did not receive evening care or HS snack until approximately 2300h. As documented by the Administrator/DOC in a progress note, a lack of hourly check rounds by all staff was apparent. Inspector #542 spoke with the Administrator/DOC who stated that the home had a fire alarm that

evening and the door was closed, and the evening staff never went to look at the resident.

On February 12, 2015, Inspector #542 was informed by the Administrator/DOC that s#-112, s#-132, and s#-133 working on that evening shift when the incident occurred, received a written warning indicating that they were neglectful. It was described in the written warning that 'this incident displays gross inaction by staff and meets the definition of resident neglect'.

Inspector reviewed employee file for s#-112 provided by Administrator/DOC. A written warning dated March 19, 2014 indicated that the staff member, on two previous occasions, did not provide evening baths to residents. In one instance, the staff member claimed that the resident refused their bath, however upon speaking with additional staff, it was determined that the resident always had their baths. The staff member stated that the second incident occurred because they forgot to do the bath.

Inspector #542 tried to interview the resident, however they were not interviewable. Inspector #595 reviewed resident #002's care plan which identified that the resident relied on staff for assistance with Activities of Daily Living, that the resident did not remember how to ring their call bell, and that staff were to reposition the resident every two hours. [s. 19. (1)]

2. The licensee failed to ensure that residents were protected from abuse by s#-104.

During stage one of the Resident Quality Inspection, resident #006 reported to Inspector #542 that there were a couple of staff at the home that shouldn't be working in this field. Resident #006 explained that they had requested that s#-104 put their clean clothes away, and s#-104 responded with 'it's not my job'. The resident then asked the staff who's job it was, and the staff member informed resident #006 that it was the family's job.

Resident #006 described another incident where this same staff member informed them that they were going to bring in a rope and tie another resident's wheelchair to theirs to enable them to pull them around. Resident #006 stated that the staff made this comment after they asked them for assistance with transporting another resident to the dining room, as that resident sometimes has difficulty propelling their wheelchair.

On February 12, 2015 Inspector #542 informed the Administrator/DOC of the above

information brought forward by resident #006. At that time the Administrator/DOC stated that s#-104 had previous discipline for inappropriate behavior and had been spoken to numerous times regarding their treatment of residents.

Inspector #542 reviewed s#-104's employee file which indicated that they recently received a written warning in 2015 for resident emotional abuse. Inspector #542 received a package from the Administrator/DOC for s#-104. In the package, Inspector #595 retrieved a letter dated 2009, which identified that s#-104 abused a resident while attending to their care in 2009. The letter further identified that the staff member was suspended, and that 'any further incidents of this nature will result in your immediate termination'. Since that time, there were two letters addressed to s#-104 which identified that they had verbally and emotionally abused residents on two separate occasions in 2014.

Five days later, on February 17, 2015, Inspector #542 spoke with the Administrator/DOC who stated that this critical incident had not been immediately reported to the Director, however would be completed.

On February 19th, 2015 Inspector #542 was informed by the Administrator/DOC that they still had not reported this critical incident to the Director as they did not initiate an investigation into the alleged abuse. [s. 19. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with 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. The licensee failed to ensure that abuse of a resident by anyone or neglect of a resident that resulted in harm or a risk of harm was immediately reported to the Director.

Inspector #542 reviewed a CI report that was submitted to the Director for an incident of staff-to-resident abuse/neglect that occurred on an evening shift in 2015. The MOHLTC after hours pager was called as notification three days later. Inspector #542 spoke with the Administrator/DOC who confirmed that the nurse working that evening should have notified the Director immediately.

On February 12, 2015 Inspector #542 informed the Administrator/DOC of an alleged abuse incident that was brought forward by resident #006. On February 17, 2015 the Administrator/DOC informed Inspector #542 that they had not reported this incident to the Director, however they would do so at that time.

Inspector #595 reviewed the home's Complaint binder as provided by the Administrator/DOC. Upon review, Inspector #595 found a progress note that identified an incident of alleged neglect by a staff member to resident #058. The resident identified that during the night, a PSW had instructed them to void in their brief and they would change them later. Inspector #595 reviewed the home's CI binder, as provided by the Administrator/DOC. Inspector could not locate a CI report to notify the Director of this

incident with resident #058.

Inspector #542 asked the Administrator/DOC if they had reported this incident to the Director. The Administrator confirmed that they had not. [s. 24. (1)]

2. The licensee failed to ensure that a person who had reasonable grounds to suspect that misuse or misappropriation of a resident's money has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #595 was informed by resident #052 that they had some money missing within a few weeks of being admitted to the home, in 2014. Inspector #542 was informed by resident #031 that they had some money missing from their possession when they lived on another home area, in 2014.

Inspector #595 reviewed the progress notes for residents #031 and #052. In 2014, the Administrator/DOC was informed by resident #031 and a friend of resident #052 that they had missing money from their possession.

Inspector #595 reviewed the home's CI binder, as provided by the Administrator/DOC. Inspector could not locate a CI report for either incident of alleged missing money. Inspector #595 approached the Administrator/DOC and it was confirmed that they had not submitted a CI to notify the Director, as the initial information provided was vague and not concrete. They believed that they did not have to submit a CI for either alleged incident of misappropriation of residents' money. [s. 24. (1)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraining of residents #032, #051, and #053 by a physical device was included in the plan of care only if alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or had not been, effective to address the risk.

Inspector #595 spoke with Administrator/DOC on February 9, 2015, who defined the home's plan of care as the resident's care plan. Inspector #580 spoke with s#-101, s#-102, and s#-103 who confirmed that they get resident care information from the care plan document.

Inspector #595 reviewed the home's policy 'Minimizing Restraining of Residents: Use of Restraints' (revised September 2014). In the policy, it indicated that the prescribing clinician should ensure that alternatives have been considered, and include any/all alternatives that were tried or considered and why they were not suitable. The policy also directed staff to refer to 'Appendix A: Decision Tree' which indicated that if there is not a serious risk to the resident or others, the interdisciplinary team is to assess and recommend approaches/alternatives, and test the alternatives. Additionally, the policy directed staff to refer to 'Appendix B: Alternative Treatment to Restraints', which outlined alternative treatments that staff were to check off when tried for high risk behaviours, including falls, wandering and restlessness/agitation/responsive behaviours.

Inspector #595 observed a seat belt in use while resident #053 was in their wheelchair. Inspector #595 reviewed the health care record for resident #053. It was indicated that the resident had a seat belt restraint on their wheelchair. It was confirmed by s#-126 and s#-127 that the resident used a seat belt as a restraint. Additionally, there was an order and signed consent for the use of the seat belt restraint. Upon review of the plan of care, the inspector could not locate a completed Alternative Treatments to Restraints form as identified in the above policy.

Inspector #595 observed resident #051 in their wheelchair with a seat belt and a second restraining device. Inspector reviewed the health care record for resident #051, and it was indicated that the resident had a seat belt restraint and a second device on their wheelchair. Additionally, there was an order and signed consent for the use of the seat belt restraint, and an order and signed consent for the second device. Both consents indicated that the seat belt and second device were restraints. It was confirmed by s#-126 that the resident had a seat belt and another restraining device. Upon review of the plan of care, the inspector could not locate a completed Alternative Treatments to Restraints form.

Inspector #580 observed resident #032 seated in a wheelchair with a seat belt applied and in bed with two full bed rails in the up position. Inspector #580 reviewed resident #032's health care record. The care plan indicated that the resident used two full bed rails and a seat belt in their wheelchair. Physician orders for the bed rails and the seat belt were also located. Inspector #580 was not able to locate an assessment for restraints and Alternative Treatment to Restraints form completed for resident #032. S#-123 and s#-124 confirmed to the inspector that resident #032 had full bed rails and a seat belt restraint. S#-123 also stated that a consent and an order for each was obtained. Inspector #580 spoke with the Administrator/DOC who confirmed that there was no restraint assessment completed for resident #032 and that there were no alternatives to restraints considered and tried.

The Administrator/DOC stated to Inspector #580 that most residents did not have the Alternative Treatments to Restraints form completed. S#-125 confirmed to the inspector that they had never completed an Alternative Treatment to Restraints form on any resident. [s. 31. (2) 2.]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 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. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contained procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected.

Inspector #542 reviewed the home's policy titled 'Zero Tolerance of Abuse and Neglect' and was unable to locate the above information. The Administrator/DOC confirmed that this specific information was missing from the policy. [s. 96. (a)]

2. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contained procedures and interventions to deal with persons who have abused or neglected or allegedly abuse or neglected residents, as appropriate.

Inspector #542 reviewed the home's policy titled 'Zero Tolerance of Abuse and Neglect' and was unable to locate the above information. The Administrator/DOC confirmed that this specific information was missing from the policy. [s. 96. (b)]

3. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identified the training and retraining requirements for all staff including 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 situation that may lead to abuse and neglect and how to avoid such situations.

Inspector #542 reviewed the home's policy titled 'Zero Tolerance of Abuse and Neglect' and was unable to locate the above information. The Administrator/DOC confirmed that this specific information was missing from the policy. [s. 96. (e)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that non-registered staff members received training by a member of the nursing staff prior to application of a topical medication.

Inspector #595 spoke with s#-127 who stated that Personal Support Workers (PSWs) do not receive training prior to application of topical medications. They explained that registered staff give them topical medications to apply during care, and if they have any questions, they are to approach the registered staff.

Inspector reviewed the home's policy 'Administering Medication' last revised January 2011. The policy stated that non-nursing staff must be trained by the registered staff prior to the administration of topicals.

Inspector #595 spoke with three PSWs, s#-128, s#-129, and s#-122 who confirmed that the home does not provide any training to PSW staff prior to application of topical medications. The staff members explained that they were worried about misapplying the topicals as they had numerous residents to care for, and some of those residents had multiple creams for various areas. They also said that some of the prescription bottles just say 'apply to affected area' and don't specify what that area is. [s. 131. (4)]

Additional Required Actions:

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

WN #8: 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. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

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:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirement was met where a resident is being restrained by a physical device: that the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in

the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's conditions or circumstances.

Throughout the RQI, Inspector #580 observed resident #032 seated in a wheelchair. Inspector #542 observed resident #032 in their wheelchair with a front-facing seat belt applied.

Inspector #580 reviewed the home's policy 'Restraints: Minimizing Restraining of Residents and Use of Restraints Program' (NUM VII-55; dated September 2014). It identified that registered staff were to reassess the resident's condition, effectiveness of the restraint, need for ongoing restraint, and potential to employ a less restrictive restraint at a minimum of every eight hours.

Inspector #580 reviewed resident #032's 'Restraint Effectiveness & Need Assessment/Reassessment' form for February 2015. It was noted that on the following shifts, the resident's full bed rails and seat belt restraint were not assessed/reassessed every eight hours by registered staff:
- February 5, 2015: evening shift
- February 6, 2015: evening shift
- February 14, 2015: day and evening shift

Inspector spoke with s#-127 who confirmed that registered staff had not completed the 'Restraint Effectiveness & Need Assessment/Reassessment' form on February 5, 6,and 14, 2015, for resident #032. [s. 110. (2) 6.]

2. The licensee failed to ensure that every use of a physical device to restrain residents #032, #051 and #053 is documented and included the following: (1) the person who applied the device and the time of application; (2) all assessment, reassessment and monitoring, including the resident's response; (3) every release of the device and all repositioning; (4) the removal or discontinuance of the device, including the time of removal or discontinuance and the post-restraining care.

Throughout the RQI, Inspector #580 observed resident #032 seated in a wheelchair. Inspector #542 observed resident #032 in their wheelchair with a front-facing seat belt.

Inspector #595 reviewed resident #032's Restraint Observation Form for their seat belt. On February 1, 2015, it was documented that the resident's restraint was applied at

1000h, and then the resident was repositioned three hours later, at 1300h. It was documented during that time that hourly checks for the restraint were completed. On February 2, 2015, the seat belt restraint was applied at 0800h, and then removed at 1300h. During that time it was documented that hourly checks were completed, and no repositioning occurred. On February 3, 4, 5, and 6, 2015, the seat belt restraint was applied at 0800h and resident was not repositioned until three hours later, at 1100h. During that time staff documented that hourly checks were completed.

Inspector #580 spoke with s#-118 who confirmed that resident #032 had not been repositioned in their wheelchair from 0800h - 1400h on February 1 and 2, 2015.

Inspector #580 reviewed the home’s policy 'Restraints: Minimizing Restraining of Residents and Use of Restraints Program' (NUM VII-55; dated September 2014). It identified that that staff were to document every hour on the restraint monitoring record and every two hours when the restraint was released and the resident was repositioned.

Inspector #595 reviewed the health care record for resident #051. The care plan indicated that the resident had a wheelchair seat belt and a second restraining device. It was also documented in the care plan that the resident was to be repositioned every two hours when restrained in their wheelchair.

Inspector spoke with s#-123, s#-104, s#-113, and s#-114 who confirmed that Personal Support Workers (PSWs) are to sign off on the 'Restraint Observation Form' on an hourly-basis to indicate when a resident's restraint was applied, removed, the resident was repositioned, and hourly checks were completed.

Inspector #595 reviewed the February 2015 'Restraint Observation Form' for resident #051. It was noted that on February 7, 2015, resident #051 was not repositioned every two hours while a restraint was in place. Inspector #595 interviewed s#-118 who confirmed that the resident was not repositioned every two hours on this day.

Inspector #595 reviewed the health care record for resident #053. The care plan indicated that the resident had a wheelchair seat belt. It was also documented in the care plan that the resident was to be repositioned every one to two hours when restrained in their wheelchair.

Inspector #595 reviewed the February 2015 'Restraint Observation Form' for resident #053. It was indicated that on February 12, 2015, resident #053 was not repositioned

every two hours when the seat belt restraint was in use.

Inspector #595 interviewed s#-118. When Inspector showed s#-118 the restraint flow sheet, indicating a lack of repositioning, the staff member explained that this resident could have exhibited responsive behaviours on this day and as a result could not be repositioned. Inspector #595 pointed out to s#-118 that staff documented 'C' on the restraint form, which meant that the resident was calm on this day. S#-118 agreed, then confirmed that the resident was not repositioned every two hours on this day. [s. 110. (7)]

3. Inspector #595 reviewed the health care record for resident #053. It was noted in the care plan that the resident had a seat belt on their wheelchair. Additionally, there was a physician's order and signed consent for the use of the seat belt as a restraint. Upon review of the care plan it was identified that Personal Support Workers (PSWs) were to sign the restraint flow sheet accordingly while the seat belt was in use.

Inspector #595 was informed by s#-113, s#-104, s#-114, and s#-102 that PSWs fill out the 'Restraint Observation Form' in the restraint binder. Inspector #595 reviewed the 'Restraint Observation Forms' for January 2015. On the forms, staff were to document every hour the resident's response (calm, sleeping or agitated) and the action taken (restraint applied, restraint removed, repositioned, hourly checks). Inspector noted that during times when the resident's seat belt restraint was typically not used, such as the evening, staff documented 'N/A' during those applicable hours. It was noted that on the following days there was no documentation: January 2, 7, 8, 9, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 26, 27, 28, 29, 30, and 31, 2015.

Inspector #595 reviewed the home's policy 'Restraints: Minimizing Restraining of Residents and Use of Restraints Program' (NUM VII-55). The policy indicated that staff were to document every hour on the restraint monitoring record and every two hours when the restraint is released and the resident is repositioned and care plan interventions have been followed. [s. 110. (7)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident is restrained, the resident's condition is reassessed and the effectiveness of restraining evaluated by a member of the registered nursing staff at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of neglect of a resident by the licensee or staff, and misuse or misappropriation of a resident's money was immediately investigated.

Inspector #595 was informed by resident #052 that they had some money missing within a few weeks of being admitted to the home. Inspector #542 was informed by resident #031 that they had some money missing from their possession when they lived on another home area, in 2014.

Inspector #595 reviewed the progress notes for residents #031 and #052. On January 23 and 24, 2014, the Administrator/DOC was informed by resident #031 and a friend of resident #052 that they had missing money from their possession.

Inspector #595 approached the Administrator/DOC and asked if the home had completed an investigation for both incidents of missing money. The Administrator stated that they did not complete an investigation as the information provided was vague and not concrete. They believed that the home did not have to complete an investigation for the alleged incident of misappropriation of residents' money.

2. Inspector #595 reviewed the home's Complaint binder as provided by the Administrator/DOC. Upon review, Inspector #595 found a progress note that identified an incident of alleged neglect by a staff member to resident #058. It was identified that during the night, a PSW had instructed the resident to void in their brief and would change them later. On February 19, 2015 Inspector #542 asked the Administrator/DOC if they had investigated this incident. The Administrator confirmed that they had not investigated the incident. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident of neglect of a resident by the licensee or staff, and misuse or misappropriation of residents' money is immediately investigated, to be implemented voluntarily.

WN #10: 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. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

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

On February 9, 2015, Inspector #542 completed the initial tour of the home. Inspector #542 observed both of the common spa rooms. In the first floor spa room, several used hair combs and brushes, an electric razor and a container of body powder with a duster where unlabelled. In the second floor spa room, the following items were unlabelled: several used hair combs and brushes, used finger nail clippers, used bar soap and another electric razor. Inspector #542 spoke with s#-107 who stated that they were the regular "bath person" and that the residents shared these common items. [s. 229. (4)]

2. The licensee failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Inspector #595 reviewed the health care record for resident #051. In the e-Notes in Medecare it was documented that a family member of resident#051 brought forward concerns about the resident's chest being congested. Resident #051 was sent for a chest x-ray and started on antibiotics the next day.

Inspector #595 interviewed two s#-113 and s#-123 who confirmed that symptoms of an infection would be documented every shift in the e-Notes. Upon review of the e-Notes at the time of the resident's infection, there was no documentation to support that staff were monitoring the symptoms of resident #051. [s. 229. (5) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program; and staff monitor and record symptoms of infection on every shift in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

Inspector #542 reviewed a CI report for an incident of staff-to-resident abuse. The CI described that a person reported that a staff member was verbally abusive towards resident #007. The home conducted an investigation which concluded that s#-122 raised their voice at the resident, and the staff member agreed that they should have backed away earlier in the conversation. Inspector #542 reviewed the employee's file and noted that they were disciplined for their actions and were provided with additional training on the home's policy and resident rights. There was no previous history of discipline for this staff member for resident abuse or neglect.

Inspector #595 reviewed the home's policy 'Zero Tolerance of Abuse and Neglect' (NUM VII-7). The policy identified that the home is committed to a zero tolerance of abuse and neglect of its residents. S#-122 did not comply with the home's policy. [s. 20. (1)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a written complaint concerning the care of a resident or the operation of the long-term care home was immediately forwarded to the Director.

Inspector #580 spoke with the Administrator/DOC who explained that a family member submitted a written complaint to the home. The complaint identified concerns with the care provided to a resident at the home. The Administrator/DOC stated that they replied to the family member in writing, but failed to forward the complaint to the Ministry of Health and Long-Term Care. [s. 22. (1)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that residents' #001, #005, and #056 plan of care was based on an interdisciplinary assessment of their sleep patterns and preferences.

During an interview in stage one of the RQI, Inspector #542 was informed by resident #001 that they cannot choose their own bedtime or wake time. The resident stated that they would like to go to bed later than 2200h and that the staff wake them up at 0800h. On February 18, 2015, Inspector #542 reviewed the resident's most recent plan of care that was available to the direct care staff, and was unable to locate any information regarding the resident's sleep patterns and preferences. Inspector #542 interviewed s#-121 and s#-122 who were unaware of the resident's sleep patterns and preferences. Inspector could not locate an interdisciplinary assessment for sleep pattern or preferences for resident #001. [s. 26. (3) 21.]

2. Inspector #595 interviewed resident #005 who indicated that they wish to get up between 0745h - 0800h, earlier than they currently do. Inspector #595 interviewed s#-113, s#-114, s#-104, and s#-102 who stated that the resident was specific with the time they wanted to get up, and will ring staff if they aren't there at a certain time. All staff stated that the resident currently gets up between 0800h and 0820h.

Inspector #595 reviewed resident #005's health care record. Upon review of the care plan, Inspector #595 noticed that the care plan did not identify that the resident wishes to be up at a certain time, as described by staff. Inspector reviewed the notes from resident #005's Annual Care Conference. It was identified that the resident voiced their wish to get up earlier than they were currently getting up. Inspector could not locate an interdisciplinary assessment for sleep pattern or preferences for resident #005. [s. 26. (3) 21.]

3. Inspector #595 interviewed resident #056 who indicated that they wish to get up whenever they want. Inspector #595 interviewed s#-114, s#-104, and s#-102 who stated that the resident was independent with their care but required cueing and minimal assistance. All three staff stated that the resident was provided care closer to 0800h - 0830h, although the resident often requests to sleep in.

Upon review of the care plan, Inspector #595 noted that the care plan did not identify that a common request from resident #056 was to request to sleep in, as described by staff. Inspector could not locate an interdisciplinary assessment for sleep pattern or preferences for resident #056. [s. 26. (3) 21.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a care conference of the interdisciplinary team providing a resident's care was held within six weeks following resident #039's admission.

Inspector #580 reviewed the health care record for resident #039 which identified that the initial care conference was not completed until 10 weeks after the resident's admission.

Inspector #580 spoke with the Administrator/DOC who confirmed that the home did not complete the care conference in six weeks. [s. 27. (1)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that resident #039 was bathed, at a minimum, twice a week.

Inspector #580 reviewed resident #039's health care record. In the care plan, the inspector could not locate the resident's designated/preferred bath days. Inspector #580 reviewed the Daily Documentation Records from November 6, 2014 - January 31, 2015, which identified resident care provided, including baths. It was confirmed by the Administrator/DOC that the Daily Documentation Record was the home's formal documentation of resident care provided. According to the records, the inspector noted that the resident did not receive a bath until two weeks after admission. Upon further review of the records, the inspector noted numerous periods where the resident did not receive two baths per week.

On February 19, 2015, Inspector #580 reviewed the Home's Bathing policy NUM VI-II7 dated July 2011 which indicated that residents will be bathed a minimum of twice per week. [s. 33. (1)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On February 9, 2015, Inspector #542 completed the initial tour of the home. Inspector #542 observed both of the common spa rooms. In the first floor spa room, several used hair combs and brushes, an electric razor and a container of body powder with a duster where unlabelled. In the second floor spa room, the following items were unlabelled: several used hair combs and brushes, used finger nail clippers, used bar soap and another electric razor. Inspector #542 spoke with s#-107 who stated that they were the regular "bath person" and that the residents shared these common items. [s. 37. (1) (a)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and O. Reg. 79/10, s. 48 (2).
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the interdisciplinary program, falls prevention and management, provided for assessment and reassessment instruments.

Inspector #595 and #542 reviewed the home's policy 'Fall Prevention/Management Program' (NUM III-27) dated September 2014. In the policy, there was no clinically appropriate assessment instrument identified to use for residents after a fall.

Inspector #542 met with the Administrator/DOC who stated that the home uses the checklist titled 'Checklist and Intervention Resource Guide for Registered Nursing Staff'. The checklist was reviewed by the Inspector and noted that it described interventions and strategies to decrease fall risk/falls, however did not include a clinically appropriate assessment instrument specifically designed for falls. Inspector #542 informed the Administrator/DOC of the above and they stated that the incident report contains an assessment. Inspector #542 asked if the incident report was considered the home's post-falls assessment instrument. The Administrator/DOC then stated "you pick which one is". [s. 48. (2)]

WN #18: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident’s admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, upon any return of the resident from hospital.

Inspector #580 reviewed resident #039's health care record. It was noted that the resident was admitted to the hospital and returned to the home five days later. Upon further review of the health care record, Inspector #580 was not able to locate a post-hospital readmission skin assessment. Inspector spoke with the Administrator/DOC who confirmed that a readmission skin assessment was not completed for resident #039 upon return to the home. [s. 50. (2) (a) (ii)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #002's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Inspector #542 reviewed a Critical Incident (CI) report for an incident of staff-to-resident neglect. It was reported that the staff working on the evening had not provided the resident any evening care nor did they complete hourly checks on the resident. On the next shift, night staff found resident #002 in their room in the dark, still in their chair with their day clothes on.

On February 12, 2015, the Administrator/DOC informed Inspector #542 that the family of resident #002 was not notified until five days after the incident. [s. 97. (1) (b)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant.

Inspector #595 was informed by resident #052 that they had some money missing within a few weeks of being admitted to the home. Inspector #542 was informed by resident #031 that they had some money missing from their possession when they lived on another home area, in 2014.

Inspector #595 reviewed the progress notes for residents #031 and #052. In 2014, the Administrator/DOC was informed by resident #031 and a friend of resident #052 that they had missing money from their possession.

Inspector #595 reviewed the home's Complaint binder as provided by the Administrator/DOC. Upon review it was noted that the home did not document either complaints. Inspector #595 asked the Administrator if they had completed the home's complaint form or documented any information. They confirmed that they did not complete a complaint form, and that that they only documented a progress note from the initial conversation with each resident and/or their family. The type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant was not documented.

Upon further review of the Complaint binder, Inspector #595 found a progress note which described an alleged incident of staff-to-resident abuse/neglect as reported by a family member. The note identified that the Administrator/DOC was made aware of the incident on October 22, 2014. Inspector #595 spoke with the Administrator/DOC who confirmed that they did not document any additional information (other than what was included in the progress note) including date of action to resolve the complaint, follow-up action required and the final resolution to the complaint.

On February 18, 2015 Inspector #580 spoke with a family member of a resident who identified that they brought complaints forward to the Administrator/DOC. Inspector #580 reviewed the home's Complaint binder and it was evident that no documentation was

completed for any complaints lodged by the family member. It was confirmed by the Administrator/DOC that the home had not completed any documentation for any complaints brought forward by the family member. [s. 101. (2)]

Issued on this 2nd day of June, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARINA MOFFATT (595), JENNIFER LAURICELLA (542), VALA MONESTIME BELTER (580)
Inspection No. / No de l'inspection :	2015_331595_0003
Log No. / Registre no:	S-000683-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 29, 2015
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 :	WILMA FLINKERT

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

Order / Ordre :

The licensee shall ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care specifically regarding residents #001, #031, #032, #033, #034, #035, #036, #037, #038, and #039.

Grounds / Motifs :

1. The licensee has failed to ensure that the written plan of care for resident #001 set out clear directions to staff and others who provide direct care to the resident.

Throughout the RQI, Inspectors #542, #580, #595 and #613 observed resident #001 in a specific location of the home upon their entrance and exit to the home each day, as well as various times throughout the day. Inspectors were in the home from February 9 - 13, 16 - 20, 2015.

Inspector #595 and #580 asked the Administrator/DOC if there was a process in place to monitor this resident while they were in this location as there was a risk for resident health and safety. The Administrator stated that this resident was on 30-minute checks by staff. They explained that staff on the resident's home area would have to go check on the resident.

On February 18, 2015, Inspector #595 spoke with s#-100 who stated that resident #001 was on strict 30-minute checks and that staff were to sign off on a flow sheet every 30 minutes and indicate where the resident was. It was noted that the flow sheets were signed off for this particular day. Inspector asked how

staff would check on them while they were in this location. The staff stated that they would either look out a window or go to the resident to see them.

Inspector #595 reviewed resident #001's care plan on February 11, 2015. The care plan did not identify that the resident was on 30-minute checks by staff and that staff were required to sign off on a flow sheet each check. [s. 6. (1) (c)] (595)

2. The licensee failed to ensure that the care plan set out clear directions to staff and others who provide care to residents #031, #032, #033, #034, #035, #036, #037, #038, and #039.

Inspector #580 spoke with s#-101, s#-102, and s#-103 who confirmed that they get resident care information from the care plan.

On February 9, 2015, Inspector #580 observed a posted list (dated December 23, 2014) in the two dining room/serveries which identified fluid consistencies for residents of that home area. Inspector spoke with s#-108 who confirmed that the sheet was meant for Personal Support Workers (PSWs) to refer to during meal times to determine resident meal requirements and diet information. It was also identified by s#-108, s#-109, s#-110, and s#-111 that nursing staff and dietary aides use the Daily Resident List (DRL) for resident diet orders, food consistency information and preferences, but will look at the posted list as well for quick reference.

Inspector #580 spoke with s#-111 who stated that according to the DRL, resident #036 received thickened fluids at meals. Inspector also observed s#-112 mixing a thickner into a liquid for resident #036. Inspector reviewed the posted quick-reference sheet which did not identify that resident #036 required thickened fluids. S#-111 and s#-112 confirmed that the posted sheet did not contain resident #036's order for thickened fluids. Inspector #580 reviewed resident #036's care plan which identified that they were to receive thickened fluids.

Upon further review, Inspector #580 identified numerous inconsistencies between the DRL, the posted lists and resident care plans. They are as follows:

Resident #032:
- Care plan identified that the resident was to receive thin fluids and prune juice

every second day; this was neither in the DRL or posted list. Additionally, the posted sheet did not identify the diet and texture as outlined in the DRL and care plan.

Resident #038:
- Care plan identified that the resident was to receive thin fluids; this was neither in the DRL or posted servery list. Additionally, the posted list did not identify the diet or texture as outlined in the DRL and care plan. The DRL also highlighted for staff to encourage fluid intake to 1500cc, however this was not in the care plan or posted list.

Resident #033:
- Care plan identified that the resident was to receive thin fluids; this was neither in the DRL or posted list. Additionally, the posted list did not identify the diet, texture, or to avoid a specific food as outlined in the DRL and care plan.

Resident #035:
- Care plan identified that the resident was to receive thin fluids; this was neither on the DRL or posted list. Additionally, the posted list did not identify the diet and texture as outlined in the DRL or care plan. The posted list and DRL also identified the use of an anti-slip mat, however this was not in the resident's care plan.

Resident #039:
- Care plan identified that the resident was to use a straw or sippy cup for fluids, however this was not in the posted list or DRL. The DRL also identified that the resident was to receive small portions, although this was not in the care plan or on the posted list. Additionally, the posted list did not identify the diet and texture as outlined in the DRL and care plan.

Resident #034:
- Care plan identified that the resident was to receive thin fluids; this was neither in the DRL or posted list. Additionally, the posted list did not identify the diet and texture as outlined in the DRL and care plan.

Resident #031:
- Care plan identified that the resident was to receive thin fluids; this was neither on the DRL or posted list. Additionally, the posted list did not identify the diet and texture as outlined in the DRL and care plan. The DRL identified the use of a

rimmed plate and non-slip mat, the posted list identified the use of just an anti-slip mat, and the care plan did not identify either intervention.

Resident #037:
- Care plan identified that resident was to have a mechanically soft diet, however the DRL identified that a regular texture was to be provided, and the posted list had no texture identified. The DRL also identified that the resident was to have fluids limited to two liters per day, although this was neither in the care plan or posted list. Additionally, the care plan and posted list highlighted that the resident was to receive one scoop of protein powder at each meal, but was not listed on the DRL. [s. 6. (1) (c)] (595)

3. During a previous inspection, #2014_332575_0015, a VPC was issued for s. 6 (1) (c).

The licensee failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to residents #032 and #039.

During the course of the inspection, Inspector #580 observed resident #032 seated in a wheelchair.

Inspector #580 spoke with s#-104 who stated that resident #032's wheelchair was tilted to relieve pressure. Another staff member, s#-105, stated that resident #032's wheelchair was tilted for comfort. Inspector also spoke with s#-106 who stated that they would tilt resident #032 if the resident asked, that they were not aware of any care plan direction about the tilt wheelchair.

Inspector #580 spoke with s#-101, s#-102, and s#-103 who confirmed that they get resident care information from the care plan. Inspector #580 reviewed resident #032's care plan which identified that the resident used a wheelchair from the home, however there was no indication that the resident used a tilt wheelchair.

Inspector #580 reviewed resident #039's health care record. Upon review of the care plan, it was noted that there was no direction or reference to the resident's bathing schedule. It was confirmed by s#-101, s#-102, and s#-103 that they get resident care information from the care plan.

Inspector #580 reviewed the home's bath list dated December 29, 2014, to February 1, 2015, for both resident home areas. The list included resident names, bath day schedule, and bath specifics including type of bath, lift required, and treatments to be completed. Inspector #580 could not locate resident #039 on either of the two bath lists in the home. [s. 6. (1) (c)] (580)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the home's resident and staff communication and response system is maintained in a safe condition, in a good state of repair and is functional.

The following must be addressed:

(1) Ensure that the communication and response system to the two identified rooms, and all other rooms is repaired and functioning at all times.

(2) Develop a system to ensure that when the call system is malfunctioning, that residents are monitored and routinely checked on.

(3) Repair the Versus system so that report times generated from the system are accurate.

(4) Audit the system to determine problem areas such as resident lights that turn green when staff are in the hallway, and repair the issues as required.

Grounds / Motifs :

1. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, specifically in regards to the Versus resident and staff communication and response system.

On February 17, 2015, Inspector #595 observed that the call bell in a resident room remained on from 1320h - 1350h. Throughout this time, one staff member, s#-118, passed by the room and did not check in or acknowledge the resident in the room. The door to the room was slightly ajar. Inspector #595 checked the call system computer at the nursing station, which did not identify that the resident's call system was activated. Inspector #613 interviewed four Personal Support Workers (PSWs) and asked if their pagers were going off. All stated that their pagers had not gone off. Inspector #595 spoke with s#-118 who stated that this resident's call bell was stuck and would not be fixed unless maintenance staff went in there. They also stated that the call bell was not registered on the computer or pagers as the call system had been shut off by the housekeeper.

Inspector #595 brought the information to the Administrative Assistant, s#-119, who rebooted the system and was able to fix the call bell temporarily. Inspector #595 asked s#-119 about the home's process for identifying and addressing call system problems. S#-119 stated that floor staff are to fill out a 'Repair Versus System/Pendants' form that identifies the problem and troubleshooting completed. The form is to be brought to s#-119 who would then further investigate the issue.

On February 18, 2015, Inspector #595 asked s#-119 if a 'Repair Versus System/Pendants' form was filled out for the call system malfunction that occurred the day prior, on February 17, 2015. They stated that no staff had filled out the report.

On February 18, 2015, Inspector #595 received a generated report from s#-119 of call bell response times. The report identified the time that a resident initiated a call and the time a staff member answered the call. It was identified by s#-119 that some of the times on the report were wrong, as the time the resident initiated the call was after the time a staff member answered the call. Inspector #595 spoke with s#-120 who stated that the error in the report was not an error due to the generation of the report, rather it was the system that was malfunctioning with incorrect times.

Later in the day, on February 18, 2015, Inspector #542 returned to the same resident room and observed the call bell on. Additionally, Inspector #542 observed that while s#-121 walked down the hall, resident lights were activated (they turned green which indicated that a staff member entered the room). The staff member confirmed that the lights should not be doing that and should only

turn green when a staff member got close to the sensor inside the resident room. S#-121 said that the call bell to the resident room often gets stuck, and stated that another resident's call light "gets stuck" and remains on. S#-121 also commented that it has happened where the entire call system shuts down, and in the case where s#-119 can't come in to fix it, the home has called in another PSW to walk the halls and check in on residents. S#-121 explained that sometimes staff will get 'phantom' calls, where the system picks up a call bell but either the resident did not initiate the bell or was not in their room to pull the bell. [s. 15. (2) (c)] (595)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 03, 2015

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure compliance with LTCHA, 2007, c. 8, s. 19 (1).

The plan must include the following:

(1) A process to ensure that all residents are monitored hourly, and that care is provided to all residents on every shift, as required. The process must include policy development and staff education to all staff who provide direct care to residents.

(2) The plan must include a review and update of the home's policy for resident abuse and neglect which meets the legislative requirements, and staff must be educated related to this policy.

(3) How the licensee will ensure that all residents are protected from abuse by staff.

The plan must be faxed to the attention of LTCH Inspector Marina Moffatt at (705) 564-3133. The plan is due on June 12, 2015 with a compliance date of June 26, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that residents were protected from abuse by s#-104.

During stage one of the Resident Quality Inspection, resident #006 reported to Inspector #542 that there were a couple of staff at the home that shouldn't be

working in this field. Resident #006 explained that they had requested that s#-104 put their clean clothes away, and s#-104 responded with 'it's not my job'. The resident then asked the staff who's job it was, and the staff member informed resident #006 that it was the family's job.

Resident #006 described another incident where this same staff member informed them that they were going to bring in a rope and tie another resident's wheelchair to theirs to enable them to pull them around. Resident #006 stated that the staff made this comment after they asked them for assistance with transporting another resident to the dining room, as that resident sometimes has difficulty propelling their wheelchair.

On February 12, 2015 Inspector #542 informed the Administrator/DOC of the above information brought forward by resident #006. At that time the Administrator/DOC stated that s#-104 had previous discipline for inappropriate behavior and had been spoken to numerous times regarding their treatment of residents.

Inspector #542 reviewed s#-104's employee file which indicated that they recently received a written warning in 2015 for resident emotional abuse. Inspector #542 received a package from the Administrator/DOC for s#-104. In the package, Inspector #595 retrieved a letter dated 2009, which identified that s#-104 abused a resident while attending to their care in 2009. The letter further identified that the staff member was suspended, and that 'any further incidents of this nature will result in your immediate termination'. Since that time, there were two letters addressed to s#-104 which identified that they had verbally and emotionally abused residents on two separate occasions in 2014.

Five days later, on February 17, 2015, Inspector #542 spoke with the Administrator/DOC who stated that this critical incident had not been immediately reported to the Director, however would be completed.

On February 19th, 2015 Inspector #542 was informed by the Administrator/DOC that they still had not reported this critical incident to the Director as they did not initiate an investigation into the alleged abuse. [s. 19. (1)] (542)

2. The licensee failed to ensure that residents are not neglected by the licensee or staff.

Inspector #542 reviewed a Critical Incident (CI) report regarding an incident of staff-to-resident neglect that occurred in 2015. The CI indicated that resident #002 was found in their room at 2300h, sitting in their chair fully clothed, the door was closed and no lights were on.

The CI report described that staff members, s#-112, s#-132 and s#-133, working the evening shift did not provide resident #002 with evening care, was not transferred to bed and hourly checks were not performed. The RPN did not check on the resident as they do not receive medication at that time of the day. Shortly after evening shift was finished, the night shift PSW completed a round and found resident #002 sitting in their chair, fully dressed, in their room, in the dark with the door closed. The resident did not receive bedtime care and was not transferred back to bed. The resident did not receive evening care or HS snack until approximately 2300h. As documented by the Administrator/DOC in a progress note, a lack of hourly check rounds by all staff was apparent. Inspector #542 spoke with the Administrator/DOC who stated that the home had a fire alarm that evening and the door was closed, and the evening staff never went to look at the resident.

On February 12, 2015, Inspector #542 was informed by the Administrator/DOC that s#-112, s#-132, and s#-133 working on that evening shift when the incident occurred, received a written warning indicating that they were neglectful. It was described in the written warning that 'this incident displays gross inaction by staff and meets the definition of resident neglect'.

Inspector reviewed employee file for s#-112 provided by Administrator/DOC. A written warning dated March 19, 2014 indicated that the staff member, on two previous occasions, did not provide evening baths to residents. In one instance, the staff member claimed that the resident refused their bath, however upon speaking with additional staff, it was determined that the resident always had their baths. The staff member stated that the second incident occurred because they forgot to do the bath.

Inspector #542 tried to interview the resident, however they were not interviewable. Inspector #595 reviewed resident #002's care plan which identified that the resident relied on staff for assistance with Activities of Daily Living, that the resident did not remember how to ring their call bell, and that staff were to reposition the resident every two hours. [s. 19. (1)] (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 2015

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that 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. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident, specifically in regards to residents #006 and #058.
2. Misuse or misappropriation of a resident's money, specifically in regards to residents #031 and #054.

Grounds / Motifs :

1. During a previous inspection, #2014_246196_001, a VPC was issued under s. 24 (1).

The licensee failed to ensure that a person who had reasonable grounds to suspect that misuse or misappropriation of a resident's money has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #595 was informed by resident #052 that they had some money missing within a few weeks of being admitted to the home, in 2014. Inspector

#542 was informed by resident #031 that they had some money missing from their possession when they lived on another home area, in 2014.

Inspector #595 reviewed the progress notes for residents #031 and #052. In 2014, the Administrator/DOC was informed by resident #031 and a friend of resident #052 that they had missing money from their possession.

Inspector #595 reviewed the home's CI binder, as provided by the Administrator/DOC. Inspector could not locate a CI report for either incident of alleged missing money. Inspector #595 approached the Administrator/DOC and it was confirmed that they had not submitted a CI to notify the Director, as the initial information provided was vague and not concrete. They believed that they did not have to submit a CI for either alleged incident of misappropriation of residents' money. [s. 24. (1)] (595)

2. The licensee failed to ensure that abuse of a resident by anyone or neglect of a resident that resulted in harm or a risk of harm was immediately reported to the Director.

Inspector #542 reviewed a CI report that was submitted to the Director for an incident of staff-to-resident abuse/neglect that occurred on an evening shift in 2015. The MOHLTC after hours pager was called as notification three days later. Inspector #542 spoke with the Administrator/DOC who confirmed that the nurse working that evening should have notified the Director immediately.

On February 12, 2015 Inspector #542 informed the Administrator/DOC of an alleged abuse incident that was brought forward by resident #006. On February 17, 2015 the Administrator/DOC informed Inspector #542 that they had not reported this incident to the Director, however they would do so at that time.

Inspector #595 reviewed the home's Complaint binder as provided by the Administrator/DOC. Upon review, Inspector #595 found a progress note that identified an incident of alleged neglect by a staff member to resident #058. The resident identified that during the night, a PSW had instructed them to void in their brief and they would change them later. Inspector #595 reviewed the home's CI binder, as provided by the Administrator/DOC. Inspector could not locate a CI report to notify the Director of this incident with resident #058.

Inspector #542 asked the Administrator/DOC if they had reported this incident to

the Director. The Administrator confirmed that they had not. [s. 24. (1)] (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 05, 2015

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Order / Ordre :

The licensee shall ensure that the restraining of a resident by a physical device is included in a resident's plan of care only if: alternatives to restraining were considered, and tried where appropriate, specifically regarding residents #032, #051 and #053.

Grounds / Motifs :

1. During a previous inspection, #2014_246196_0001, a VPC was issued for s. 31 (2).

The licensee failed to ensure that the restraining of residents #032, #051, and #053 by a physical device was included in the plan of care only if alternatives to

restraining the resident have been considered, and tried where appropriate, but would not be, or had not been, effective to address the risk.

Inspector #595 spoke with Administrator/DOC on February 9, 2015, who defined the home's plan of care as the resident's care plan. Inspector #580 spoke with s#-101, s#-102, and s#-103 who confirmed that they get resident care information from the care plan document.

Inspector #595 reviewed the home's policy 'Minimizing Restraining of Residents: Use of Restraints' (revised September 2014). In the policy, it indicated that the prescribing clinician should ensure that alternatives have been considered, and include any/all alternatives that were tried or considered and why they were not suitable. The policy also directed staff to refer to 'Appendix A: Decision Tree' which indicated that if there is not a serious risk to the resident or others, the interdisciplinary team is to assess and recommend approaches/alternatives, and test the alternatives. Additionally, the policy directed staff to refer to 'Appendix B: Alternative Treatment to Restraints', which outlined alternative treatments that staff were to check off when tried for high risk behaviours, including falls, wandering and restlessness/agitation/responsive behaviours.

Inspector #595 observed a seat belt in use while resident #053 was in their wheelchair. Inspector #595 reviewed the health care record for resident #053. It was indicated that the resident had a seat belt restraint on their wheelchair. It was confirmed by s#-126 and s#-127 that the resident used a seat belt as a restraint. Additionally, there was an order and signed consent for the use of the seat belt restraint. Upon review of the plan of care, the inspector could not locate a completed Alternative Treatments to Restraints form as identified in the above policy.

Inspector #595 observed resident #051 in their wheelchair with a seat belt and a second restraining device. Inspector reviewed the health care record for resident #051, and it was indicated that the resident had a seat belt restraint and a second device on their wheelchair. Additionally, there was an order and signed consent for the use of the seat belt restraint, and an order and signed consent for the second device. Both consents indicated that the seat belt and second device were restraints. It was confirmed by s#-126 that the resident had a seat belt and another restraining device. Upon review of the plan of care, the inspector could not locate a completed Alternative Treatments to Restraints form.

Inspector #580 observed resident #032 seated in a wheelchair with a seat belt applied and in bed with two full bed rails in the up position. Inspector #580 reviewed resident #032's health care record. The care plan indicated that the resident used two full bed rails and a seat belt in their wheelchair. Physician orders for the bed rails and the seat belt were also located. Inspector #580 was not able to locate an assessment for restraints and Alternative Treatment to Restraints form completed for resident #032. S#-123 and s#-124 confirmed to the inspector that resident #032 had full bed rails and a seat belt restraint. S#-123 also stated that a consent and an order for each was obtained. Inspector #580 spoke with the Administrator/DOC who confirmed that there was no restraint assessment completed for resident #032 and that there were no alternatives to restraints considered and tried.

The Administrator/DOC stated to Inspector #580 that most residents did not have the Alternative Treatments to Restraints form completed. S#-125 confirmed to the inspector that they had never completed an Alternative Treatment to Restraints form on any resident. [s. 31. (2) 2.] (595)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 05, 2015

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 96. 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.

Order / Ordre :

The licensee shall ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contains the following:
1. Procedures and interventions to assist and support residents who have been abused or neglected, or allegedly abused or neglected.
2. Procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate.
3. Training and retraining requirements for all staff including 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 situation that may lead to abuse and neglect and how to avoid such situations.

Grounds / Motifs :

1. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contained procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected.

Inspector #542 reviewed the home's policy titled 'Zero Tolerance of Abuse and Neglect' and was unable to locate the above information. The Administrator/DOC confirmed that this specific information was missing from the policy. [s. 96. (a)] (542)

2. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contained procedures and interventions to deal with persons who have abused or neglected or allegedly abuse or neglected residents, as appropriate.

Inspector #542 reviewed the home's policy titled 'Zero Tolerance of Abuse and Neglect' and was unable to locate the above information. The Administrator/DOC confirmed that this specific information was missing from the policy. [s. 96. (b)] (542)

3. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identified the training and retraining requirements for all staff including 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 situation that may lead to abuse and neglect and how to avoid such situations.

Inspector #542 reviewed the home's policy titled 'Zero Tolerance of Abuse and Neglect' and was unable to locate the above information. The Administrator/DOC confirmed that this specific information was missing from the policy. [s. 96. (e)] (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 2015

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,

(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals;

(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and

(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Order / Ordre :

The licensee shall ensure that staff who are not otherwise permitted to administer a topical medication to a resident has received training by a member of the registered nursing staff in the administration of topicals.

Grounds / Motifs :

1. The licensee failed to ensure that non-registered staff members received training by a member of the nursing staff prior to application of a topical medication.

Inspector #595 spoke with s#-127 who stated that Personal Support Workers (PSWs) do not receive training prior to application of topical medications. They explained that registered staff give them topical medications to apply during care, and if they have any questions, they are to approach the registered staff.

Inspector reviewed the home's policy 'Administering Medication' last revised January 2011. The policy stated that non-nursing staff must be trained by the registered staff prior to the administration of topicals.

Inspector #595 spoke with three PSWs, s#-128, s#-129, and s#-122 who confirmed that the home does not provide any training to PSW staff prior to application of topical medications. The staff members explained that they were worried about misapplying the topicals as they had numerous residents to care for, and some of those residents had multiple creams for various areas. They also said that some of the prescription bottles just say 'apply to affected area' and don't specify what that area is. [s. 131. (4)] (595)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 2015

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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:

1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Order / Ordre :

The licensee shall ensure that every use of a physical device to restrain a resident is documented, including:

1. The person who applied the device and the time of application;
2. All assessment, reassessment and monitoring, including the resident's response;
3. Every release of the device and all repositioning; and
4. The removal or discontinuance of the device, including the time of removal or discontinuance and the post-restraining care.

Grounds / Motifs :

1. During two previous inspections, #2014_332575_0015 and #2014_246196_0001, a VPC was issued under r. 110 (7).

The licensee failed to ensure that every use of a physical device to restrain

residents #032, #051 and #053 is documented and included the following: (1) the person who applied the device and the time of application; (2) all assessment, reassessment and monitoring, including the resident's response; (3) every release of the device and all repositioning; (4) the removal or discontinuance of the device, including the time of removal or discontinuance and the post-restraining care.

Throughout the RQI, Inspector #580 observed resident #032 seated in a wheelchair. Inspector #542 observed resident #032 in their wheelchair with a front-facing seat belt.

Inspector #595 reviewed resident #032's Restraint Observation Form for their seat belt. On February 1, 2015, it was documented that the resident's restraint was applied at 1000h, and then the resident was repositioned three hours later, at 1300h. It was documented during that time that hourly checks for the restraint were completed. On February 2, 2015, the seat belt restraint was applied at 0800h, and then removed at 1300h. During that time it was documented that hourly checks were completed, and no repositioning occurred. On February 3, 4, 5, and 6, 2015, the seat belt restraint was applied at 0800h and resident was not repositioned until three hours later, at 1100h. During that time staff documented that hourly checks were completed.

Inspector #580 spoke with s#-118 who confirmed that resident #032 had not been repositioned in their wheelchair from 0800h - 1400h on February 1 and 2, 2015.

Inspector #580 reviewed the home's policy 'Restraints: Minimizing Restraining of Residents and Use of Restraints Program' (NUM VII-55; dated September 2014). It identified that that staff were to document every hour on the restraint monitoring record and every two hours when the restraint was released and the resident was repositioned.

Inspector #595 reviewed the health care record for resident #051. The care plan indicated that the resident had a wheelchair seat belt and a second restraining device. It was also documented in the care plan that the resident was to be repositioned every two hours when restrained in their wheelchair.

Inspector spoke with s#-123, s#-104, s#-113, and s#-114 who confirmed that Personal Support Workers (PSWs) are to sign off on the 'Restraint Observation

Form' on an hourly-basis to indicate when a resident's restraint was applied, removed, the resident was repositioned, and hourly checks were completed.

Inspector #595 reviewed the February 2015 'Restraint Observation Form' for resident #051. It was noted that on February 7, 2015, resident #051 was not repositioned every two hours while a restraint was in place. Inspector #595 interviewed s#-118 who confirmed that the resident was not repositioned every two hours on this day.

Inspector #595 reviewed the health care record for resident #053. The care plan indicated that the resident had a wheelchair seat belt. It was also documented in the care plan that the resident was to be repositioned every one to two hours when restrained in their wheelchair.

Inspector #595 reviewed the February 2015 'Restraint Observation Form' for resident #053. It was indicated that on February 12, 2015, resident #053 was not repositioned every two hours when the seat belt restraint was in use.

Inspector #595 interviewed s#-118. When Inspector showed s#-118 the restraint flow sheet, indicating a lack of repositioning, the staff member explained that this resident could have exhibited responsive behaviours on this day and as a result could not be repositioned. Inspector #595 pointed out to s#-118 that staff documented 'C' on the restraint form, which meant that the resident was calm on this day. S#-118 agreed, then confirmed that the resident was not repositioned every two hours on this day. [s. 110. (7)] (595)

2. Inspector #595 reviewed the health care record for resident #053. It was noted in the care plan that the resident had a seat belt on their wheelchair. Additionally, there was a physician's order and signed consent for the use of the seat belt as a restraint. Upon review of the care plan it was identified that Personal Support Workers (PSWs) were to sign the restraint flow sheet accordingly while the seat belt was in use.

Inspector #595 was informed by s#-113, s#-104, s#-114, and s#-102 that PSWs fill out the 'Restraint Observation Form' in the restraint binder. Inspector #595 reviewed the 'Restraint Observation Forms' for January 2015. On the forms, staff were to document every hour the resident's response (calm, sleeping or agitated) and the action taken (restraint applied, restraint removed, repositioned, hourly checks). Inspector noted that during times when the resident's seat belt

restraint was typically not used, such as the evening, staff documented 'N/A' during those applicable hours. It was noted that on the following days there was no documentation: January 2, 7, 8, 9, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 26, 27, 28, 29, 30, and 31, 2015.

Inspector #595 reviewed the home's policy 'Restraints: Minimizing Restraining of Residents and Use of Restraints Program' (NUM VII-55). The policy indicated that staff were to document every hour on the restraint monitoring record and every two hours when the restraint is released and the resident is repositioned and care plan interventions have been followed. [s. 110. (7)] (595)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 29th day of May, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Marina Moffatt

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