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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 16, 2018	2018_638609_0005	001734-18	Resident Quality Inspection

Licensee/Titulaire de permis

St. Joseph's Health Centre of Sudbury
1140 South Bay Road SUDBURY ON P3E 0B6

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

St. Joseph's Villa, Sudbury
1250 South Bay Road SUDBURY ON P3E 6L9

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

CHAD CAMPS (609), MICHELLE BERARDI (679), SHEILA CLARK (617), STEPHANIE DONI (681)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 26-28, March 1-2 and March 5-9, 2018.

Additional logs inspected during this RQI included:

One intake related to Compliance Order (CO) #001 from inspection #2017-615638-0012, s. 6. (7) of the Long-Term Care Homes Act (LTCHA), 2007, specific to care provided to residents as specified in the plan;

One intake related to CO #002 from inspection #2017-615638-0012, r. 50. (2) (b) (iv) of the Ontario Regulation (O.Reg.) 79/10, specific to weekly skin assessments;

Six complaints related to the home’s nursing and personal support staffing levels;

One complaint related to allegations of abuse to a resident;

One Critical Incident (CI) report submitted by the home to the Director related to staff to resident abuse;

Three CI reports submitted by the home to the Director related to resident falls; and

Nine CI reports submitted by the home to the Director related to resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Administrator, Medical Director, Director of Care (DOC), Assistant Director of Care (ADOC), Manager of Environmental Services (MES), Life Enrichment Program Coordinator, Food Services Manager (FSM), Food Services Supervisor (FSS), Dietitian, Physiotherapist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Care Aides (PCAs), Food Service Aides (FSAs), family members and residents.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, reviewed relevant health care records, internal investigations and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

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
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
14 WN(s)
6 VPC(s)
3 CO(s)
1 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 50. (2)	CO #002	2017_615638_0012	681

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Resident #005 was identified as frequently incontinent from their Resident Assessment Instrument Minimum Data Set (MDS).

Inspector #617 reviewed resident #005's most recent MDS assessment which indicated that they were frequently incontinent.

A review of resident #005's care plan indicated that due to their incontinence care needs they required a specified number of staff for assistance.

In an interview with resident #005, they outlined their incontinence regime which differed from the documented care plan.

During an interview with PCA #147, they outlined and verified resident #005's incontinence regime as described by the resident. The PCA reviewed the resident’s care plan and confirmed that the resident’s incontinence regime was not in their care plan.

A review of the home's policy titled, "Care Planning- Clinical Services", last updated on July 5, 2017, indicated that assessments including information provided by the resident and/or significant others about the resident's history, needs, and preferences, were to

have been included in the resident's plan of care.

In an interview with the DOC, they confirmed that resident #005's preferences and routines were to be communicated within the interdisciplinary team and updated as part of their plan of care as per policy. [s. 6. (2)]

2. A) On three particular days, Inspector #617 observed PCA #151, PCA #144 and #145 porter resident #002 to various locations. The Inspector observed that during the portering of resident #002, the resident was required to perform an identified task.

A review of resident #002's care plan found no mention of the identified task when portering the resident.

In interviews with PCAs #144 and #145, they both verified that resident #002 was required to perform the identified task when being portered.

Both the Inspector and PCA #144 reviewed resident #002's care plan and the PCA confirmed to the Inspector that the care plan did not indicate the identified task.

In an interview with the DOC, they confirmed to the Inspector that when portering resident #002 the identified task was required and should have been in the resident's care plan.

B) On four particular days, Inspector #617 observed PCAs, #108, #127, #144, and #145, porter resident #010. The Inspector observed that during the portering of resident #010, an identified intervention was used by staff.

A review of resident #010's care plan found no indication of the identified intervention used by staff when portering the resident.

In interviews with PCAs #108, #144 and #145, they all reported that resident #010 required the identified intervention when being portered.

Both the Inspector and PCA #144 reviewed resident #010's care plan together, and the PCA confirmed to the Inspector that the identified intervention to be used when portering was in their care plan.

In an interview with the DOC, they reported to the Inspector that the identified

intervention was to be in resident #010's care plan. [s. 6. (2)]

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

A Compliance Order (CO) #001 was issued to the home to address the licensee’s failure to comply with s. 6. (7) of the Long Term Care Homes Act (LTCHA), 2007. The CO required the home to prepare, submit, and implement a plan to ensure that the care set out in the plan of care was provided to the resident as specified in their plan of care. The plan shall include, but not limited to,

A) How the licensee will ensure that for every resident in the home, staff will provide care as specified in each resident’s plan of care, including the care of residents #015, #018, #020, and #021.
B) How the licensee will ensure that residents’ fluids will be thickened to their assessed needs.

The compliance due date of this order was October 13, 2017.

While the licensee complied section "a" for the four identified residents, additional findings non-compliance were identified. In addition, findings of non-compliance were identified with section "b", where the licensee was ordered to ensure that residents’ fluids were thickened to their assessed needs.

During an observation on a particular day, Inspector #681 observed resident #040 trying to consume a fluid that was not at the resident's identified consistency.

During another observation on a different day, resident #040's was provided fluids that were again not at the identified consistency.

A review of resident #040's current plan of care indicated that all fluids were to be provided at an identified consistency.

A review of the home’s definition for the consistency of resident #040's fluids provided by RD #133, verified that the fluids provided to resident #040 on the particular days were not the resident's required consistency.

During an interview with PCA #105, they indicated that they prepared resident #040’s

fluids on one of the particular days and used an incorrect measurement which resulted in resident #040 being provided fluids not at their required consistency.

During an interview with RPN #104, they stated that resident #040 was supposed to receive fluids at an identified consistency. RPN #104 verified that the fluids served to resident #040 on one of the particular days was not at the required consistency.

The fluids that were served to resident #040 on one of the particular days, were brought to FSS #103 who stated that the fluids were not at the required consistency.

During an interview with RD #133, they indicated that, despite widespread education throughout the home, audits had still been identifying concerns related to inappropriate fluid consistencies. RD #133 stated that improper fluid consistencies were the result of staff not preparing the fluids correctly based on the directions that were provided to them. [s. 6. (7)]

4. On a particular day, Inspector #617 interviewed resident #010's family member who reported that the resident was not provided with appropriate incontinence care and as a result damaged a piece of the resident's equipment.

A review of resident #010's MDS indicated that the resident was incontinent. A review of resident #010's care plan outlined an identified incontinence care regime.

On a particular day, resident #010 was observed continuously for a specified time frame and was not provided with incontinence care by staff.

During interviews with PCAs, #145, #127, #108 and #105, all were scheduled and working the shift on the particular day of the Inspectors observations and verified that the incontinence care provided to resident #010 was not as specified in their incontinence care regime.

A review of the home's policy titled, "Care Planning-Clinical Services", last updated on July 5, 2017, indicated that the inter-professional team members were to provide care to the resident as set out in the plan.

In an interview with the DOC, they confirmed that staff were supposed to follow the care set out in the plan as per the home's policy.

Through observations and interviews it was determined that on the particular day, resident #010 was not provided incontinence care as specified in the regime outlined in their plan of care. [s. 6. (7)]

5. Eight CI reports were submitted to the Director related to allegations of resident to resident physical abuse involving resident #012. The CI reports indicated that on eight separate days, resident #012 was involved in altercations that resulted in injury to other residents. The CI reports identified that all of these incidents occurred in one of two identified areas of the home.

Inspector #681 reviewed the resident's care plan, which indicated under the focus "Physically Responsive Behaviours", that staff were to employ specific behavioural interventions with the resident.

During an interview with resident #012's Substitute Decision-Maker (SDM), they stated that they believed that resident #012's behaviours were partly due to the specified interventions not being employed by the staff.

Inspector #681 observed resident #012 during two time frames on two particular days and found the resident without any of the specified interventions. In both time frames resident #012 became physically responsive.

During an interview with PCA #138, they verified the specified interventions that were to have been employed with resident #012.

During an interview with RPN #136, they verified the specified interventions that were in place for resident #012.

During an interview with the DOC, they indicated that the specified interventions included in resident #012's care plan should have been employed. [s. 6. (7)]

6. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A CI report was submitted to the Director, which outlined how resident #015 fell resulting in an injury.

On a particular day, Inspector #609 observed resident #015 with an intervention in use.

A review of resident #015's current plan of care found that the intervention required care at specific time intervals.

During an interview with PCA #105, they verified that resident #015's required care was provided as per the specified time intervals.

A review of the PCA Point of Care (POC) records for resident #015 failed to document that the specified care was provided to the resident.

A review of the home's policy titled "Documentation" last revised January 20, 2017, required documentation to include the care and services provided to the resident.

During an interview with the DOC they verified that there was no task within Point of Care for the PCAs to document the required care at the specified time intervals for resident #015 and that it should have been there. [s. 6. (9) 1.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

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

WN #2: 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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included: Any mood and behaviour patterns, including wandering; Any identified responsive behaviours; and any potential behavioural triggers and variations in resident functioning at different times of the day.

A CI report was submitted by the home to the Director which outlined how on a particular day, resident #015 and resident #006 had an altercation which resulted in resident #015 sustaining injuries.

On two separate days, Inspector #609 observed resident #015 demonstrating a specific responsive behaviour.

During an interview with resident #015's SDM, they outlined how the resident was known to demonstrate the specified responsive behaviour.

A review of resident #015's health care records for a particular time frame found that prior to and after the CI, the resident was observed demonstrating the specified responsive behaviour.

During an interview with PCA #105, they verified that others could trigger resident #015's specified responsive behaviour when they performed an identified activity.

A review of resident #015's plan of care found no mention of the resident's trigger or their specified responsive behaviour.

A review of the home's policy titled "Responsive Behaviours" last revised August 14, 2017, indicated that the resident's plan of care was to identify responsive behaviours.

During an interview with the ADOC, a review of resident #015's health care records was conducted. The ADOC verified that the resident's specified responsive behavior as well as trigger should have been included in the resident's plan of care. [s. 26. (3) 5.]

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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the organized program of nursing services for the home met the assessed needs of the residents.

On a particular day, Inspector #609 overheard staff indicate that the home was short of registered staff.

During an interview with RN #124, they verified that the home was short one RN as well as one day shift RPN and as a result they were responsible for the 0800 hours morning medication pass on one of the home's units, which they were more than two hours behind completing.

During an interview with resident #041 on the same day, verified that their 0800 hours morning medications were administered over one hour late.

A review of the home’s policy titled “The Medication Pass” last revised January 2018 indicated that the resident was to receive the correct medication at the correct time.

During an interview with the Administrator and DOC, they outlined how resident medications were to be administered to the resident between one hour before and one hour after the prescribed administration time.

A review of the “Physician's Orders Audit Report” on the particular day shift on the unit found that of the residents that required 0800 hours medication or had prescribed tasks, all residents or 100 per cent, were not administered their scheduled medications, nor had their prescribed task completed, within the two hour allotment.

A further review of the “Physician's Orders Audit Report” for the particular day shift on the unit found that of the residents that required 0800 hours medication or had prescribed tasks, 17 per cent were administered their medications or had their prescribed tasks completed, greater than five hours past the prescribed time.

During the same interview with the Administrator and DOC, they verified that regardless of staffing levels in the home, residents were to be administered their medications within the time specified by the prescriber. Both the DOC and the Administrator denied any awareness that the shortage of registered staff had impacted residents, their medication administration times or the completion of their prescribed tasks. [s. 8. (1) (a)]

2. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

A) Inspector #609 reviewed the home's staffing levels for a 59 day period and found that the home was short one or more PCAs on a given unit every day or 100 per cent of the review period.

During an interview with resident #022, they outlined that when the unit was short PCAs that they would have to wait longer for staff to respond to their activated call bell.

A review of the home's policy titled “Nurse Call System” last revised May 26, 2017, required PCAs to respond to the residents' room in a timely manner to answer residents' calls. The policy further indicated that besides a brief message to the resident via the speaker system, the nurse would need to respond to the room to cancel the call.

During an interview with PCA #107, they indicated that between two and three minutes would be a timely response time and that when the unit was short of PCAs, call bell response times increased.

During an interview with RPN #137, they explained that two to three minutes would be an appropriate call bell response time and that staffing shortages affected those response times.

A review of the PCA staffing on a particular day, found that the home was short two PCA staff during the afternoon shift. A review of the call bell response report for an identified unit's afternoon shift, found two call bells that went longer than 10 minutes before being

cancelled.

A review of the PCA staffing level on another day's afternoon shift found that the home was short five PCAs. A review of the call bell response report for the identified unit's afternoon shift, found six call bells that went longer than 10 minutes before being cancelled.

A further review of the PCA staffing level on a different day's afternoon shift found that the home was short seven PCAs. A review of the call bell response report for the identified unit's afternoon shift, found 14 call bells that went longer than 10 minutes before being cancelled.

During an interview with the Administrator, they defined a timely manner as responding to a call bell as soon as possible and acknowledged that shortages of PCAs affected call bell response times.

B) In an interview with Inspector #617, resident #005 reported that they required a specified toileting regime. Resident #005 confirmed that often in the afternoon and evening, they would wait a long time for the staff to respond to their call bell and they would be in a lot of pain because they weren't toileted soon enough.

On a particular day, the Inspector observed resident #005 in their room, at the doorway to the bathroom crying and upset because they had been waiting half an hour for staff to assist them onto the toilet.

A review of the call bell response report for resident #005 on the particular day, found that the call for assistance was not answered for a period of 27 minutes.

A review of the PCA staffing level on the particular day's day shift found the home was short one PCA, while the afternoon shift was short two PCAs. [s. 8. (1) (b)]

3. Four complaints were submitted to the Director related to insufficient staffing of PCA's to meet the needs of the residents.

A) Inspector #679 reviewed the first of the four complaints submitted to the Director regarding insufficient staffing. The complaint outlined that resident #032 did not receive their bath on a particular day, as a result of being short staffed.

In an interview with resident #032, they identified that they had missed their bath twice because of staffing shortages. Resident #032 was unable to provide any further detail regarding the dates of their missed bath.

In an interview with PCA #106, they identified that when the home was short staffed, aspects of resident care including bathing could be affected. PCA #106 further acknowledged that on another particular day, the home was short staffed and as a result, resident #031 did not receive their bath.

Inspector #679 reviewed the electronic Point of Care (POC) records for resident #031 and found that the resident did not receive their bath for seven days.

In an interview with resident #031, they identified that they had missed their bath because of staffing levels. Resident #031 was unable to provide any further details regarding the dates of their missed baths.

In a separate interview with Inspector #609, PCA #106 identified that the unit was short one PCA on a particular day and that resident #038 did not receive their bath.

A review of the POC records identified that there was no documentation to support that resident #038 received their bath.

A review of the policy entitled “Bathing- complete, partial, tub baths and showers” last revised February 21, 2018, identified that residents/patients were offered two baths per week. The policy further identified that staff were to document the care completed or the care refused in Point of Care.

In an interview with the DOC, they confirmed that resident #031 did not receive their scheduled bath. The DOC and Inspector #679 reviewed the electronic documentation for resident #038; The DOC identified that there was no documentation to support that resident #038 received their scheduled bath. The DOC identified it would be the expectation that the residents receive their scheduled baths.

B) Inspector #679 reviewed the second complaint submitted to the Director regarding insufficient staffing. The complaint outlined that on a particular day, the nourishment cart was not passed on an identified unit as a result of insufficient staffing.

A review of the POC documentation for the identified unit on the particular day, identified

that there was no documentation completed for any of the residents on the unit to identify that the nourishment cart was passed.

A review of the policy entitled “Nourishments” last revised on January 20, 2017, indicated that snacks and/or refreshments would be offered to all residents/patients at mid-morning, mid-afternoon and at bedtime.

In an interview with resident #005, they indicated that they do not always receive a nourishment cart pass. Resident #005 identified this occurred “a lot”.

In a separate interview with Inspector #609, PCA #106 identified that the home was short on another day and that as a result the afternoon nourishment cart was not provided.

Inspector #679 and the DOC reviewed the documentation for a particular day, which was short three PCAs on the day shift. The DOC confirmed that there was no documentation to identify that the nourishment cart had been passed. Further, the DOC indicated that it would be the expectation that the documentation was completed to identify that the nourishment cart had been passed.

C) Inspector #679 reviewed the third complaint submitted to the Director regarding insufficient staffing. The complaint alleged that the home was short three PCA’s on night shift. The complaint further alleged that there were no staff to assist with resident’s who required more than one staff member for their continence needs.

A review of the PCA schedule on a particular day identified that there were four PCA’s on the schedule for the night shift.

A review of the policy entitled “Staffing Plan” last revised on December 1, 2017, identified that the staffing complement for PCA’s on a night shift would be six PCA’s.

In an interview with PCA #134, they identified that residents #035 and #036 required the assistance of more than one staff member.

In an interview with resident #035, they indicated that there was usually one staff member who assisted them with care at night.

In an interview with resident #036, they identified that there was typically one person who assisted them during the night.

A review of resident #036's care plan identified that the resident required more than one staff member for assistance.

In an interview with PCA #113, they identified that when the home worked short staffed on a night shift, there was no time for others to assist with residents who required more than on person assistance. PCA #113 identified that they had to perform approximately half of the residents who require more than one person assistance independently. PCA #113 further identified that they have had to leave a unit unattended to assist another unit.

In an interview with PCA #140, they identified that they have had to provide care to a resident who required more than one person assistance independently. PCA #140 further identified that when the home was short staffed on a night shift, sometimes only one round was completed for the residents who require more than one person assistance. PCA #140 identified that there were typically two rounds completed on a night shift.

In an interview with PCA #141, they identified that when the home was short staffed on a night shift, sometimes only one round was completed for the residents who require more than one person assistance.

In an interview with RN #143, they identified that the home was short staffed on night shift "almost every night". RN #143 identified that when the home was short the two float PCAs, then the PCAs would complete care for the residents who require more than one person assistance on rounds.

In an interview with the DOC, they identified that it would be the expectation that residents who required the assistance of more than one staff member, would be provided care as specified.

D) Inspector #679 reviewed the last complaint submitted to the Director for concerns regarding insufficient staffing. The complainant identified that during the summer months, they would have to occasionally wait up to one hour for assistance. An additional complaint submitted to the Director alleged that resident #039 had to wait one hour for toileting assistance.

An observation was conducted on a particular day on an identified unit. It was identified that resident #034's call bell was ringing for 17 minutes, and resident #035's call bell was

ringing for 11 minutes.

In an interview with resident #035, they identified that they couldn't recall how long they were waiting for, however, they identified that they typically have to wait a long time (10 to 15 minutes) for staff to respond to their call bell.

In an interview with resident #043, they identified that they sometimes had to wait a long time (15 to 20 minutes) for staff to respond to their call bells.

In an interview with PCA #122, they identified that two to four minutes would be an acceptable wait time for a resident call bell to be answered. PCA #122 further identified that the response to a bathroom call bell should be quicker.

In an interview with RPN #129, they identified that an acceptable wait time for a call bell to be answered in order to identify the nature of the residents concern, would be approximately two minutes.

In an interview with the DOC, they identified that an acceptable wait time for a call bell to be answered would be "as soon as possible". Inspector #679 inquired if 11 to 16 minute wait times would be considered appropriate. The DOC identified that these times would be considered acceptable if the staff were busy assisting other residents with care.

E) Inspector #679 reviewed the POC charting for on a particular day for an identified unit and observed that documentation to identify the care provided to the residents was missing for 17 residents.

A review of the policy entitled "Documentation" last revised on January 20, 2017, identified that PCAs were to document in POC as soon as possible after the event had occurred. The policy further identified that documentation provided evidence that care requirements had been met, and that the interventions of team members had been delivered.

In an interview with PCA #106 on a particular day, they identified that the unit was working short one PCA. In a separate interview conducted with Inspector #609, PCA #106 identified that when the unit was short staffed, the documentation will at times not get done.

In an interview with RPN #129, they identified that all documentation should be

completed by the end of each shift. RPN #129 further identified that staffing shortages were a barrier to completing documentation.

In an interview with the DOC, they identified that staffing levels were not an excuse for documentation to be missed, and that documentation should be completed after the care was provided.

In an interview with the DOC, they indicated that the staffing levels of the home were meeting the needs of the residents. Further, the DOC explained that the staffing levels weren’t affecting resident care, but rather staff morale and that the instances outlined above were related to staffing performance issues, rather than staffing levels.

F) Inspector #679 reviewed the home’s Resident Council Meeting Minutes which identified that the “crisis of being short staffed appeared to be worse than ever affecting all shifts”.

G) A review of the home’s Family Council Minutes which identified that the council requested a plan to address the staffing shortages in the home. The Family Council further identified that there had been times where there were only two PCA’s in a unit and that the Family Council felt that residents were being put at risk.

H) During additional interviews with four other residents of the home, they identified to Inspector #679 that they felt the home did not have enough staff to ensure they got the care and assistance they required without having to wait a long time.

In an interview with the Administrator, they identified that the home had been working short staffed almost every day and that was why it had been called a staffing crisis.

In a separate interview with Inspector #617, the Chief Executive Officer (CEO) identified that the home was in a PCA staffing crisis. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home
Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

During the initial tour of the home, Inspector #609 found the door to a clean utility room unlocked and unattended. Inside the room oxygen tanks, equipment and supplies such as razors were noted.

During an interview with PSW #100 they verified that the door to the specified clean utility room was to be locked when unattended and that the battery to the lock was dead. The PSW immediately notified maintenance staff to change the battery.

A review of the home’s policy titled “Security and Access to Building (Visiting Hours)” last reviewed November 7, 2017, required all doors leading to service areas to be equipped with locks to restrict unsupervised access to those areas by residents.

During an interview with the Manager of Environmental Services (MES) they verified that the clean utility rooms were considered service areas and should have been locked at all times when unattended. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #5: 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 has failed to ensure that the home’s written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A CI report was submitted by the home to the Director, which outlined how on a particular day PCA #131 alleged that they witnessed PCA #132 physically abuse resident #011.

Inspector #609 reviewed the home’s internal investigation notes which found that the allegations of abuse were unsubstantiated.

A review of the home’s policy titled “Zero Tolerance For Abuse and Neglect” last revised November 3, 2017, required any employee who witnessed, became aware of or suspected resident abuse were to report it immediately to the DOC/Administrator/delegate, who would then ensure a thorough and confidential investigation was initiated.

During an interview with the DOC, they outlined how PCA #131 notified them of allegations of abuse toward resident #011 five days after the alleged incident. The DOC verified that all allegations of abuse or neglect of a resident were to be immediately reported to the DOC or delegate and that this did not occur.

As a result PCA #131 received counseling to ensure that any allegations of abuse or neglect was immediately reported to the home. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home’s written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A CI report was submitted to the Director regarding resident #014's fall on a particular day which resulted in the resident sustaining injuries. The next day the resident was transferred to the hospital.

A review of resident #014’s care plan and a physiotherapist assessment, both indicated that the resident required staff assistance and the use of a mobility aid for mobility.

In an interview with Physiotherapist #123 they confirmed to the Inspector that they had assessed resident #014. Their assessment had provided direction for staff to assist the resident with their mobility aid for long distances.

A review of resident #014’s post fall assessment, on the date the CI occurred, described how PCA #148 portered the resident with their mobility aid and described the probable cause that resulted in the resident falling causing injury. The assessment stated that interventions to prevent further falls indicated that a specified intervention should be used.

In interviews with RPN #149 and PCA #148, they both reported that resident #014 required to be portered with their mobility aid and that the resident was required to perform a specified task when being portered. The PCA confirmed that at the time of resident #014’s fall, they were rushed and did not ensure that the resident was performing the specified task and as a result the resident fell.

In interviews with PCAs #112, #146 and #144, they all reported to the Inspector that when portering residents, they would ensure that the resident performed the specified task. The PCAs confirmed that ensuring the resident performed the specified task was not listed in the residents’ care plans.

In an interview with the DOC, they reported that their investigation into the CI indicated that prevention of the occurrence would have been that PCA #148 did not rush the resident and portered the resident in a certain manner. The DOC had further indicated to the Inspector that they had expected staff to ensure that all residents portered were to perform the specified task if required and that this would not have been listed in their care plans. [s. 36.]

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 use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 77. Food service workers, minimums

Specifically failed to comply with the following:

s. 77. (1) Every licensee of a long-term care home shall ensure that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2) for,
(a) the preparation of resident meals and snacks; O. Reg. 79/10, s. 77 (1).
(b) the distribution and service of resident meals; O. Reg. 79/10, s. 77 (1).
(c) the receiving, storing and managing of the inventory of resident food and food service supplies; and O. Reg. 79/10, s. 77 (1).
(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service. O. Reg. 79/10, s. 77 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there were sufficient food service workers for the home to meet the minimum staffing hours outlined in the Ontario Regulation 79/10.

Section 77 (2) of the Ontario Regulation 79/10, identifies that a home with a licensed bed capacity of 128 beds would require 403 food service worker hours per week for:

A) the preparation of resident meals and snacks;
B) the distribution and service of resident meals;
C) the receiving, storing and managing of the inventory of resident food and food service supplies; and
D) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service.

A complaint was received by the Director related to insufficient food service assistants to distribute food during meal service. A complaint was also received by the Director related to meals not being served on time.

Inspector #681 observed the dinner meal service in a specific dining room on a particular day and found that there was only one staff member available to serve dinner to two dining rooms.

During an interview with RPN #150, they stated that they usually work evening shifts on one specific unit and that the unit was short a food services assistant approximately 60 percent of time.

Inspector #681 reviewed the usual staffing compliment for food service workers at the home, which indicated that 420.5 hours were to be worked by food service workers each week. The Inspector reviewed the number of hours worked by food service workers during two one week periods. A total of 390.5 hours were worked for one week while 391 hours were worked for the other.

During an interview with the Food Services Manager (FSM), they stated that the home had been short food service workers the past three weekends because they were unable to fill sick calls. The FSM acknowledged that the home had not been meeting the minimum required hours for food service workers. [s. 77. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there are sufficient food service workers for the home to meet the minimum staffing hours outlined in the Ontario Regulation 79/10, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspector #679 observed a specific home area during the lunch meal service on a particular day. During the meal service the Inspector observed Food Service Worker (FSW) #121 rubbing their face with their bare hands and rubbing their arms with their gloved hands while handling food.

In an interview with FSW #121, they identified that they were expected to wash their hands “every minute”. Further, FSW #121 acknowledged that it would be the expectation that they wash their hands prior to handling food.

A review of the policy entitled “Safe Food Handling” issued September 20, 2010, identified that staff were to wash their hands thoroughly in accordance with the “Hand Hygiene” policy. The policy further identified that staff were to keep hands and fingers away from the face, hair, nose and mouth where food poisoning organisms can be picked up and transmitted to food.

A review of the policy entitled “Hand Hygiene” issued in June 2009, identified that hand hygiene was imperative before initial patient/patient environment contact and after patient/resident environment contact.

In an interview with the FSS, they identified that staff were expected to perform hand hygiene prior to serving meals, as well as when moving from one task to another. The FSS identified that it would be the expectation that staff members perform hand hygiene prior to handling food after rubbing their face, or their arm.

In an interview with the DOC, they identified that staff members would perform hand hygiene prior to handling food after rubbing their face or arm. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #9: 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 has 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 cleaned as required.

A CI report was submitted to the Director, which outlined how resident #015 fell resulting in injuries.

On a particular day, Inspector #609 observed resident #015's mobility aid which had crusted white, yellow and brown residue on the frame and wheels. At the same time, resident #019's mobility aid was observed with significantly crusted and caked on yellow, brown, white, and red residue.

During an interview with RPN #101, they verified that the mobility aids for resident #015 and #019 were dirty. They then indicated that night staff were responsible for cleaning resident mobility aids as outlined on the “Nightshift Bath Schedule” and that they were often not completed.

A review of the unit's "Nightshift Bath Schedule" indicated that both resident #015 and #019 were to have their mobility aids cleaned weekly on a particular day.

A review of the home's policy titled "Mobility Aids- Cleaning of" last revised May 26, 2017, required residents' mobility aids be cleaned when visibly soiled or according to a schedule.

During an interview with the DOC, they verified that the mobility aids for resident #015 and #019 were dirty. A review of documentation with the DOC found that resident #015's mobility aid was last cleaned nine days previously, while resident #019's mobility aid was last cleaned seven days previously. The DOC acknowledged that staff should be cleaning mobility aids according to the schedule as well as at the time they become dirty. [s. 37. (1) (b)]

2. A complaint was submitted to the Director, regarding resident #013's mobility aid not being cleaned as required. During the time of inspection resident #013 was no longer residing in the home and the Inspector selected another resident with a mobility aid to observe.

On three particular days, Inspector #617 observed resident #010's mobility aid to have dried debris on the base frame.

In an interview with resident #010's family member, they reported that they visited the resident frequently and have observed that the resident's mobility aid had not been cleaned on a regular basis and that the majority of the time the mobility aid was dirty.

In an interview with PCA #127, they reported that the night staff were responsible for cleaning the mobility aids and was not aware of the schedule or how the mobility aids were to be cleaned. The PCA confirmed that resident #010's mobility aid was dirty and then proceeded to clean the mobility aid. [s. 37. (1) (b)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies were implemented to respond to the resident demonstrating responsive behaviours, where possible.

A CI report was submitted by the home to the Director, which outlined how resident #015 had an altercation with resident #006 on a particular day, which resulted in resident #015 sustaining injuries.

Inspector #609 reviewed resident #015’s health care records and found for the one month previous and one month after the altercation, the resident had six incidents of responsive behaviour directed either at other residents or staff.

A review of the home’s policy titled “Responsive Behaviours” last revised August 14, 2017, indicated that the resident’s plan of care was to identify strategies to minimize behaviours, respond effectively when they do occur and may include medications to prevent/manage the responsive behaviours.

A review of resident #015’s physician orders found the resident had medications for managing their responsive behaviours.

A review of resident #015’s Medication Administration Record (MAR) found that of the six incidents documented the resident was not provided the medications 67 per cent of the time.

During an interview with RPN #120, a review of resident #015’s MAR was completed. The RPN indicated they were unsure when the ordered medications were to be used for the resident.

During an interview with RPN #130, they verified that when resident #015 demonstrated responsive behaviours, they were to follow the interventions in the plan of care as well as administer medications as ordered.

During an interview with the Medical Director (MD), a review of the six incidents as well as MARs for resident #015 were conducted. The MD verified that registered staff were to have administered the medications when the resident was demonstrating responsive behaviours and that this did not occur. [s. 53. (4) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 82. Attending physician or RN (EC)

Specifically failed to comply with the following:

s. 82. (1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,
(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination; O. Reg. 79/10, s. 82 (1).
(b) attends regularly at the home to provide services, including assessments; and O. Reg. 79/10, s. 82 (1).
(c) participates in the provision of after-hours coverage and on-call coverage. O. Reg. 79/10, s. 82 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that either a physician or a registered nurse in the extended class, conducted a physical examination of each resident upon admission and an annual physical examination annually thereafter, produced a written report of the findings of the examination and attended regularly at the home to provide services, including assessments.

A complaint was submitted to the Director which indicated that the home had hired a new physician and the concern was that the physician was not available to the residents in a timely manner.

Inspector #617 reviewed the Medical Director's signed contract with the home, which indicated that the physician was expected to visit the facility regularly, at least once every second week, in order to carry out their responsibilities under the agreement and was expected to perform admission assessments and annual reassessments on the residents.

In an interview with the Medical Director, they reported that they were the sole physician providing medical services to the home's 128 residents. They further reported that they were required to attend the home twice weekly and confirmed that they attended the home five days a week usually in the morning for half days.

In an interview with resident #005, they reported that for a period of a four month time frame they had not been seen by the physician. The resident reported that at the last meeting with the physician, they told the physician that they were having specific health concerns. The resident felt the physician did not hear their concerns at that time and did not follow up.

A review of the Family Council and Resident Council meeting minutes, indicated that there were concerns about the availability of the physician; lack of communication between the SDM, nurses, and physician; and that only one physician was not able to provide medical services to 128 residents.

In an interview with the Administrator, they confirmed that at both the Family Council and Resident Council meetings, the aforementioned concerns were brought forward. The Administrator confirmed that there was a gap in the communication between the registered staff and the physician and that a communication system was not in place at the time. The Administrator confirmed that Medical Director was the sole physician for 128 residents and was in the process for recruiting another physician.

A review of the home's policy titled "Annual Physical Examination Clinical Services" last revised on October 21, 2016, indicated that the attending physician was to complete a physical examination at admission and annually thereafter. The date of the last physical examination was to be recorded under Custom Information in Point Click Care (PCC), by the Unit Assistant. Upon request, the physician was to be provided with a list of physical examinations that were due.

A review of the home's Resident List Report indicating the last documented date for the residents' annual physical examination, to have been completed by the physician, indicated that 24 out of 126 residents, or 19 per cent of the residents, had annual physicals that were not completed within the last year.

Of the 24 outdated annual physical examinations not completed within the last year:
-two residents had no documentation of a completed admission examination;
-two residents had their last physical examination dated in 2013, or five years ago;
-seven resident had their last physical examination dated in 2014, or four years ago;
-one resident had their last physical examination dated in 2015, or three years ago;
-eight residents had their last physical examination dated in 2016, or two years ago; and
-four residents had their last physical examination dated in 2017, or over one year ago.

In an interview with the Medical Director, they confirmed that they had been hired as the sole physician in the facility and since then had attempted to complete all the resident annual physicals. They confirmed that they were behind and have not completed all the residents' annual physicals, further explaining that the home did not have a process lead by the RN to organize and schedule the residents' annual physicals.

In an interview with the DOC, they confirmed that the home's policy was for the Administrative Assistant to have reviewed and compiled the list of residents' annual physicals and the RN was to communicate the need for the annuals to be completed to the physician. The DOC confirmed that this process was not occurring and the physician's annual assessments were not up to date. [s. 82. (1)]

WN #12: 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 has failed to ensure that the resident’s SDM, if any, and any other person specified by the resident, were notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

A) A CI report was submitted by the home to the Director which outlined how resident #006 had an altercation with resident #015, which resulted in resident #015 sustaining injuries.

Inspector #609 reviewed the current MDS assessment for resident #006 which indicated that the resident had memory loss and that their decisions were not consistent or reasonable.

A review of resident #006’s health care records found that the resident had an enacted SDM for care decisions, yet no documentation was found indicating that the resident’s SDM was notified of the alteration with resident #015.

A review of the home’s policy titled “Critical Incident Disclosure” last revised December 13, 2017, required disclosure of critical incidents to the resident’s SDM if the resident was incapable.

During an interview with the ADOC, a review of resident #006’s health care records was conducted. The ADOC verified that the resident’s SDM should have been notified of the CI involving the resident and that this did not occur.

B) Eight CI reports were submitted to the Director related to allegations of resident to resident physical abuse involving resident #012.

Inspector #681 reviewed resident #012s progress notes, which indicated that for a specified time frame, resident #012 was involved in incidents of physically responsive behaviours involving other residents.

During an interview with resident #012's SDM, they indicated that there was no communication between themselves and the home during the specified time frame. [s. 97. (1) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

A CI report was submitted to the Director which outlined how two days previously, resident #015 fell resulting in injury and transfer to hospital.

Inspector #609 reviewed the home’s policy titled “Critical Incident” last revised December 13, 2017, which required the Director be notified within one business day of an injury where a resident was taken to hospital with a significant change in their health condition.

During an interview with the DOC, they verified that they had completed the CI report two days after the incident because they had defined a significant change as one that impacted two or more of the resident’s activities of daily living.

O.Reg. 79/10 defines a significant change in the resident's health condition as one that will not resolve itself without further intervention, impacts on more than one aspect of the resident's health condition, and requires an assessment by the interdisciplinary team or a revision to the resident's plan of care.

During the same interview with the DOC, the definition of a significant change was reviewed. The DOC verified that resident #015’s injuries would not resolve without further intervention, impacted on more than one aspect of their health condition, required an assessment by the interdisciplinary team as well as a revision of their plan of care and therefore constituted a significant change in the resident’s health condition.

The DOC acknowledged that by the Regulation's definition of a significant change in health condition, the CI report was reported late by one day. [s. 107. (3) 4.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate double-locked stationary cupboard in the locked area or stored in a separate locked area within the medication cart.

On a particular day, Inspector #679 and RN #116 completed an observation of the emergency stock medication box, located on a specific unit. It was identified that the emergency stock box, which contained controlled substances that were stored in a removable locked tool box, within a single locked cupboard located in the locked medication room.

A review of the policy entitled "Storage of Medication" dated February 2017, outlined that all monitored medications were safely stored to comply with the legislative and home requirements.

In an interview with RPN #104, they identified that the emergency stock box was stored in the specified unit medication room and that the RN carried the key.

In an interview with RN #116, they identified that the emergency stock box was triple locked and stored in the specified unit (the medication room, the cupboard, and the tool box). Further, RN #116 verified that the emergency stock box contained controlled substances.

The licensee has failed to ensure that the controlled substances were stored in a double-locked stationary cupboard in the locked medication area. [s. 129. (1) (b)]

Issued on this 18th day of May, 2018

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

Original report signed by the inspector.

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHAD CAMPS (609), MICHELLE BERARDI (679), SHEILA CLARK (617), STEPHANIE DONI (681)
Inspection No. / No de l'inspection :	2018_638609_0005
Log No. / No de registre :	001734-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 16, 2018
Licensee / Titulaire de permis :	St. Joseph's Health Centre of Sudbury 1140 South Bay Road, SUDBURY, ON, P3E-0B6
LTC Home / Foyer de SLD :	St. Joseph's Villa, Sudbury 1250 South Bay Road, SUDBURY, ON, P3E-6L9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Roger Leveille

To St. Joseph's Health Centre of Sudbury, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2017_615638_0012, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 6. (7) of the Long Term Care Homes Act (LTCHA).

Specifically, the licensee must:

a) Ensure that staff provide care to resident #012 as per their responsive behaviour plan of care.

b) Ensure that resident #012 is engaged in interventions that are clearly identified in the resident's plan of care.

c) Ensure that staff provide care to resident #010 as per their bowel/bladder continence plan of care.

d) Ensure that resident #040 is provided all fluids at their assessed consistency as outlined in their nutritional plan of care.

e) Ensure that all staff of the home who may thicken or provide thickened fluids to residents are retrained so that all residents are provided fluids at the consistency set out in their plans of care.

Grounds / Motifs :

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

A Compliance Order (CO) #001 was issued to the home to address the licensee's failure to comply with s. 6. (7) of the Long Term Care Homes Act (LTCHA), 2007. The CO required the home to prepare, submit, and implement a plan to ensure that the care set out in the plan of care was provided to the resident as specified in their plan of care. The plan shall include, but not limited to,

A) How the licensee will ensure that for every resident in the home, staff will provide care as specified in each resident's plan of care, including the care of residents #015, #018, #020, and #021.
B) How the licensee will ensure that residents' fluids will be thickened to their assessed needs.

The compliance due date of this order was October 13, 2017.

While the licensee complied section "a" for the four identified residents, additional findings non-compliance were identified. In addition, findings of non-compliance were identified with section "b", where the licensee was ordered to ensure that residents' fluids were thickened to their assessed needs.

During an observation on a particular day, Inspector #681 observed resident #040 trying to consume a fluid that was not at the resident's identified consistency.

During another observation on a different day, resident #040's was provided fluids that were again not at the identified consistency.

A review of resident #040's current plan of care indicated that all fluids were to be provided at an identified consistency.

A review of the home's definition for the consistency of resident #040's fluids provided by RD #133, verified that the fluids provided to resident #040 on the particular days were not the resident's required consistency.

During an interview with PCA #105, they indicated that they prepared resident #040's fluids on one of the particular days and used an incorrect measurement which resulted in resident #040 being provided fluids not at their required consistency.

During an interview with RPN #104, they stated that resident #040 was supposed to receive fluids at an identified consistency. RPN #104 verified that the fluids served to resident #040 on one of the particular days was not at the required consistency.

The fluids that were served to resident #040 on one of the particular days, were brought to FSS #103 who stated that the fluids were not at the required consistency.

During an interview with RD #133, they indicated that, despite widespread education throughout the home, audits had still been identifying concerns related to inappropriate fluid consistencies. RD #133 stated that improper fluid consistencies were the result of staff not preparing the fluids correctly based on the directions that were provided to them. [s. 6. (7)] (609)

2. On a particular day, Inspector #617 interviewed resident #010's family member who reported that the resident was not provided with appropriate incontinence care and as a result damaged a piece of the resident's equipment.

A review of resident #010's MDS indicated that the resident was incontinent. A review of resident #010's care plan outlined an identified incontinence care regime.

On a particular day, resident #010 was observed continuously for a specified time frame and was not provided with incontinence care by staff.

During interviews with PCAs, #145, #127, #108 and #105, all were scheduled and working the shift on the particular day of the Inspectors observations and verified that the incontinence care provided to resident #010 was not as specified in their incontinence care regime.

A review of the home's policy titled, "Care Planning-Clinical Services", last updated on July 5, 2017, indicated that the inter-professional team members were to provide care to the resident as set out in the plan.

In an interview with the DOC, they confirmed that staff were supposed to follow the care set out in the plan as per the home's policy.

Through observations and interviews it was determined that on the particular

day, resident #010 was not provided incontinence care as specified in the regime outlined in their plan of care. [s. 6. (7)] (617)

3. Eight CI reports were submitted to the Director related to allegations of resident to resident physical abuse involving resident #012. The CI reports indicated that on eight separate days, resident #012 was involved in altercations that resulted in injury to other residents. The CI reports identified that all of these incidents occurred in one of two identified areas of the home.

Inspector #681 reviewed the resident's care plan, which indicated under the focus "Physically Responsive Behaviours", that staff were to employ specific behavioural interventions with the resident.

During an interview with resident #012's Substitute Decision-Maker (SDM), they stated that they believed that resident #012's behaviours were partly due to the specified interventions not being employed by the staff.

Inspector #681 observed resident #012 during two time frames on two particular days and found the resident without any of the specified interventions. In both time frames resident #012 became physically responsive.

During an interview with PCA #138, they verified the specified interventions that were to have been employed with resident #012.

During an interview with RPN #136, they verified the specified interventions that were in place for resident #012.

During an interview with the DOC, they indicated that the specified interventions included in resident #012's care plan should have been employed. [s. 6. (7)]

The severity of this issue was determined to be a level two, as there was the potential for actual harm/risk to the residents of the home. The scope of the issue was a level two, or a pattern where residents were not provided with care as specified in their plans of care. The home had a level four compliance history, as they had ongoing non-compliance with this section of the LTCHA that included a:

-voluntary plan of correction (VPC) issued October 14, 2015, (#2015_320612_0020);

-compliance order (CO) #008 issued June 6, 2016, with a compliance due date (CDD) of July 31, 2016 (#2016_264609_0007);

-CO #004 issued March 3, 2017, with a CDD of May 15, 2017, (#2016_273638_0020);

-written notification (WN) issued March 30, 2017, (#2017_615638_0007); and

-director referral (DR) and CO #001 issued September 27, 2017, with a CDD of November 24, 2017, (#2017_615638_0012). (681)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 18, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The licensee must be compliant with Ontario Regulation (O. Reg.) 79/10, s. 26 (3).

Specifically the licensee must complete and keep a record of an interdisciplinary assessment of resident #015's mood and behaviour patterns, including identified responsive behaviours and triggers, so that they are outlined in the resident's plan of care.

Grounds / Motifs :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included: Any mood and behaviour patterns, including wandering; Any identified responsive behaviours; and any potential behavioural triggers and variations in resident functioning at different times of the day.

A CI report was submitted by the home to the Director which outlined how on a particular day, resident #015 and resident #006 had an altercation which resulted in resident #015 sustaining injuries.

On two separate days, Inspector #609 observed resident #015 demonstrating a specific responsive behaviour.

During an interview with resident #015’s SDM, they outlined how the resident was known to demonstrate the specified responsive behaviour.

A review of resident #015’s health care records for a particular time frame found that prior to and after the CI, the resident was observed demonstrating the specified responsive behaviour.

During an interview with PCA #105, they verified that others could trigger resident #015’s specified responsive behaviour when they performed an identified activity.

A review of resident #015’s plan of care found no mention of the resident's trigger or their specified responsive behaviour.

A review of the home’s policy titled “Responsive Behaviours” last revised August

14, 2017, indicated that the resident's plan of care was to identify responsive behaviours.

During an interview with the ADOC, a review of resident #015's health care records was conducted. The ADOC verified that the resident's specified responsive behavior as well as trigger should have been included in the resident's plan of care. [s. 26. (3) 5.]

The severity of this issue was determined to be a level two, as there was the potential for actual harm/risk to the residents of the home. The scope of the issue was a level one, or isolated to resident #015 plan of care. The home had a level four compliance history, as they had ongoing non-compliance with this section of O. Reg. 79/10 that included a:

-voluntary plan of correction (VPC) issued June 6, 2016, (#2016_264609_0007);

-VPC issued March 30, 2017, (#2017_615638_0007); and

-VPC issued August 30, 2017, (#2017_615638_0012). (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 18, 2018

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8. (1) of the LTCHA.

Specifically the licensee must ensure that:

a) The registered staffing level provides for residents to be administered their medications between one hour before and one hour after the time as specified by the prescriber.

b) The direct care staffing level provides for resident #031, #032, #038 and all other resident with their scheduled/preferred bath.

c) The direct care staffing level provides for all residents to receive snacks and/or refreshments as specified within the home's policy titled “Nourishments” last revised on January 20, 2017.

d) The direct care staffing level provides for resident #035, #036 and all other resident, care by the appropriate number of staff required, as per their plans of care.

e) Staff are to document the provision (or lack of provision) of care they provide to residents.

Grounds / Motifs :

1. The licensee has failed to ensure that the organized program of nursing services for the home met the assessed needs of the residents.

On a particular day, Inspector #609 overheard staff indicate that the home was short of registered staff.

During an interview with RN #124, they verified that the home was short one RN as well as one day shift RPN and as a result they were responsible for the 0800 hours morning medication pass on one of the home's units, which they were more than two hours behind completing.

During an interview with resident #041 on the same day, verified that their 0800 hours morning medications were administered over one hour late.

A review of the home's policy titled "The Medication Pass" last revised January 2018 indicated that the resident was to receive the correct medication at the correct time.

During an interview with the Administrator and DOC, they outlined how resident medications were to be administered to the resident between one hour before and one hour after the prescribed administration time.

A review of the "Physician's Orders Audit Report" on the particular day shift on the unit found that of the residents that required 0800 hours medication or had prescribed tasks, all residents or 100 per cent, were not administered their scheduled medications, nor had their prescribed task completed, within the two hour allotment.

A further review of the "Physician's Orders Audit Report" for the particular day shift on the unit found that of the residents that required 0800 hours medication or had prescribed tasks, 17 per cent were administered their medications or had their prescribed tasks completed, greater than five hours past the prescribed time.

During the same interview with the Administrator and DOC, they verified that regardless of staffing levels in the home, residents were to be administered their medications within the time specified by the prescriber. Both the DOC and the Administrator denied any awareness that the shortage of registered staff had impacted residents, their medication administration times or the completion of

their prescribed tasks. [s. 8. (1) (a)] (609)

2. Four complaints were submitted to the Director related to insufficient staffing of PCA's to meet the needs of the residents.

A) Inspector #679 reviewed the first of the four complaints submitted to the Director regarding insufficient staffing. The complaint outlined that resident #032 did not receive their bath on a particular day, as a result of being short staffed.

In an interview with resident #032, they identified that they had missed their bath twice because of staffing shortages. Resident #032 was unable to provide any further detail regarding the dates of their missed bath.

In an interview with PCA #106, they identified that when the home was short staffed, aspects of resident care including bathing could be affected. PCA #106 further acknowledged that on another particular day, the home was short staffed and as a result, resident #031 did not receive their bath.

Inspector #679 reviewed the electronic Point of Care (POC) records for resident #031 and found that the resident did not receive their bath for seven days.

In an interview with resident #031, they identified that they had missed their bath because of staffing levels. Resident #031 was unable to provide any further details regarding the dates of their missed baths.

In a separate interview with Inspector #609, PCA #106 identified that the unit was short one PCA on a particular day and that resident #038 did not receive their bath.

A review of the POC records identified that there was no documentation to support that resident #038 received their bath.

A review of the policy entitled “Bathing- complete, partial, tub baths and showers” last revised February 21, 2018, identified that residents/patients were offered two baths per week. The policy further identified that staff were to document the care completed or the care refused in Point of Care.

In an interview with the DOC, they confirmed that resident #031 did not receive their scheduled bath. The DOC and Inspector #679 reviewed the electronic

documentation for resident #038; The DOC identified that there was no documentation to support that resident #038 received their scheduled bath. The DOC identified it would be the expectation that the residents receive their scheduled baths.

B) Inspector #679 reviewed the second complaint submitted to the Director regarding insufficient staffing. The complaint outlined that on a particular day, the nourishment cart was not passed on an identified unit as a result of insufficient staffing.

A review of the POC documentation for the identified unit on the particular day, identified that there was no documentation completed for any of the residents on the unit to identify that the nourishment cart was passed.

A review of the policy entitled “Nourishments” last revised on January 20, 2017, indicated that snacks and/or refreshments would be offered to all residents/patients at mid-morning, mid-afternoon and at bedtime.

In an interview with resident #005, they indicated that they do not always receive a nourishment cart pass. Resident #005 identified this occurred “a lot”.

In a separate interview with Inspector #609, PCA #106 identified that the home was short on another day and that as a result the afternoon nourishment cart was not provided.

Inspector #679 and the DOC reviewed the documentation for a particular day, which was short three PCAs on the day shift. The DOC confirmed that there was no documentation to identify that the nourishment cart had been passed. Further, the DOC indicated that it would be the expectation that the documentation was completed to identify that the nourishment cart had been passed.

C) Inspector #679 reviewed the third complaint submitted to the Director regarding insufficient staffing. The complaint alleged that the home was short three PCA’s on night shift. The complaint further alleged that there were no staff to assist with resident’s who required more than one staff member for their continence needs.

A review of the PCA schedule on a particular day identified that there were four

PCA's on the schedule for the night shift.

A review of the policy entitled "Staffing Plan" last revised on December 1, 2017, identified that the staffing complement for PCA's on a night shift would be six PCA's.

In an interview with PCA #134, they identified that residents #035 and #036 required the assistance of more than one staff member.

In an interview with resident #035, they indicated that there was usually one staff member who assisted them with care at night.

In an interview with resident #036, they identified that there was typically one person who assisted them during the night.

A review of resident #036's care plan identified that the resident required more than one staff member for assistance.

In an interview with PCA #113, they identified that when the home worked short staffed on a night shift, there was no time for others to assist with residents who required more than on person assistance. PCA #113 identified that they had to perform approximately half of the residents who require more than one person assistance independently. PCA #113 further identified that they have had to leave a unit unattended to assist another unit.

In an interview with PCA #140, they identified that they have had to provide care to a resident who required more than one person assistance independently. PCA #140 further identified that when the home was short staffed on a night shift, sometimes only one round was completed for the residents who require more than one person assistance. PCA #140 identified that there were typically two rounds completed on a night shift.

In an interview with PCA #141, they identified that when the home was short staffed on a night shift, sometimes only one round was completed for the residents who require more than one person assistance.

In an interview with RN #143, they identified that the home was short staffed on night shift "almost every night". RN #143 identified that when the home was short the two float PCAs, then the PCAs would complete care for the residents

who require more than one person assistance on rounds.

In an interview with the DOC, they identified that it would be the expectation that residents who required the assistance of more than one staff member, would be provided care as specified.

D) Inspector #679 reviewed the last complaint submitted to the Director for concerns regarding insufficient staffing. The complainant identified that during the summer months, they would have to occasionally wait up to one hour for assistance. An additional complaint submitted to the Director alleged that resident #039 had to wait one hour for toileting assistance.

An observation was conducted on a particular day on an identified unit. It was identified that resident #034's call bell was ringing for 17 minutes, and resident #035's call bell was ringing for 11 minutes.

In an interview with resident #035, they identified that they couldn't recall how long they were waiting for, however, they identified that they typically have to wait a long time (10 to 15 minutes) for staff to respond to their call bell.

In an interview with resident #043, they identified that they sometimes had to wait a long time (15 to 20 minutes) for staff to respond to their call bells.

In an interview with PCA #122, they identified that two to four minutes would be an acceptable wait time for a resident call bell to be answered. PCA #122 further identified that the response to a bathroom call bell should be quicker.

In an interview with RPN #129, they identified that an acceptable wait time for a call bell to be answered in order to identify the nature of the residents concern, would be approximately two minutes.

In an interview with the DOC, they identified that an acceptable wait time for a call bell to be answered would be "as soon as possible". Inspector #679 inquired if 11 to 16 minute wait times would be considered appropriate. The DOC identified that these times would be considered acceptable if the staff were busy assisting other residents with care.

E) Inspector #679 reviewed the POC charting for on a particular day for an identified unit and observed that documentation to identify the care provided to

the residents was missing for 17 residents.

A review of the policy entitled "Documentation" last revised on January 20, 2017, identified that PCAs were to document in POC as soon as possible after the event had occurred. The policy further identified that documentation provided evidence that care requirements had been met, and that the interventions of team members had been delivered.

In an interview with PCA #106 on a particular day, they identified that the unit was working short one PCA. In a separate interview conducted with Inspector #609, PCA #106 identified that when the unit was short staffed, the documentation will at times not get done.

In an interview with RPN #129, they identified that all documentation should be completed by the end of each shift. RPN #129 further identified that staffing shortages were a barrier to completing documentation.

In an interview with the DOC, they identified that staffing levels were not an excuse for documentation to be missed, and that documentation should be completed after the care was provided.

In an interview with the DOC, they indicated that the staffing levels of the home were meeting the needs of the residents. Further, the DOC explained that the staffing levels weren't affecting resident care, but rather staff morale and that the instances outlined above were related to staffing performance issues, rather than staffing levels.

F) Inspector #679 reviewed the home's Resident Council Meeting Minutes which identified that the "crisis of being short staffed appeared to be worse than ever affecting all shifts".

G) A review of the home's Family Council Minutes which identified that the council requested a plan to address the staffing shortages in the home. The Family Council further identified that there had been times where there were only two PCA's in a unit and that the Family Council felt that residents were being put at risk.

H) During additional interviews with four other residents of the home, they identified to Inspector #679 that they felt the home did not have enough staff to

ensure they got the care and assistance they required without having to wait a long time.

In an interview with the Administrator, they identified that the home had been working short staffed almost every day and that was why it had been called a staffing crisis.

In a separate interview with Inspector #617, the Chief Executive Officer (CEO) identified that the home was in a PCA staffing crisis. [s. 8. (1) (b)] (679)

3. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

A) Inspector #609 reviewed the home's staffing levels for a 59 day period and found that the home was short one or more PCAs on a given unit every day or 100 per cent of the review period.

During an interview with resident #022, they outlined that when the unit was short PCAs that they would have to wait longer for staff to respond to their activated call bell.

A review of the home's policy titled "Nurse Call System" last revised May 26, 2017, required PCAs to respond to the residents' room in a timely manner to answer residents' calls. The policy further indicated that besides a brief message to the resident via the speaker system, the nurse would need to respond to the room to cancel the call.

During an interview with PCA #107, they indicated that between two and three minutes would be a timely response time and that when the unit was short of PCAs, call bell response times increased.

During an interview with RPN #137, they explained that two to three minutes would be an appropriate call bell response time and that staffing shortages affected those response times.

A review of the PCA staffing on a particular day, found that the home was short two PCA staff during the afternoon shift. A review of the call bell response report for an identified unit's afternoon shift, found two call bells that went longer than

10 minutes before being cancelled.

A review of the PCA staffing level on another day's afternoon shift found that the home was short five PCAs. A review of the call bell response report for the identified unit's afternoon shift, found six call bells that went longer than 10 minutes before being cancelled.

A further review of the PCA staffing level on a different day's afternoon shift found that the home was short seven PCAs. A review of the call bell response report for the identified unit's afternoon shift, found 14 call bells that went longer than 10 minutes before being cancelled.

During an interview with the Administrator, they defined a timely manner as responding to a call bell as soon as possible and acknowledged that shortages of PCAs affected call bell response times.

B) In an interview with Inspector #617, resident #005 reported that they required a specified toileting regime. Resident #005 confirmed that often in the afternoon and evening, they would wait a long time for the staff to respond to their call bell and they would be in a lot of pain because they weren't toileted soon enough.

On a particular day, the Inspector observed resident #005 in their room, at the doorway to the bathroom crying and upset because they had been waiting half an hour for staff to assist them onto the toilet.

A review of the call bell response report for resident #005 on the particular day, found that the call for assistance was not answered for a period of 27 minutes.

A review of the PCA staffing level on the particular day's day shift found the home was short one PCA, while the afternoon shift was short two PCAs. [s. 8. (1) (b)]

The severity of this issue was determined to be a level two, as there was the potential for actual harm/risk to the residents of the home. The scope of the issue was a level two or a pattern of staffing shortages affecting resident care. The home had a level three compliance history, as they had related non-compliance with this section of the LTCHA that included a:

-CO #001 issued January 8, 2016, with a CDD of February 5, 2016,

(#2015_320612_0020); and

-CO #001 issued June 6, 2016, with a CDD of October 27, 2016, (#2016_264609_0007). (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 08, 2018

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, commercial courier or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 16th day of April, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Chad Camps

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