**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

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

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

**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 17, 2014 | 2014_280541_0030 | O-000866-14 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

TRENT VALLEY LODGE LIMITED
195 Bay Street, TRENTON, ON, K8V-1H6

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

TRENT VALLEY LODGE LIMITED
195 BAY STREET, TRENTON, ON, K8V-1H9

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

AMBER MOASE (541), BARBARA ROBINSON (572), PAUL MILLER (143)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): September 2-5 and September 8-12, 2014.**

**In addition to the RQI, two complaint inspections were completed.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Life Enrichment Coordinator, the Food Service Supervisor, the Maintenance Manager, Registered Nurses, the RAI coordinator, Registered Practical Nurses, the Administrative Assistant, the Unit Clerk, Personal Support Workers, Residents and Family Members.**

**During the course of the inspection, the inspector(s) conducted a tour of the home and interviewed resident and family members. Observed meal service, staff to resident interactions, medication administration and practices, infection control practices and program activities. Reviewed the licensee's policies related to Restraints, Medications and Skin and Wound care. Reviewed Family and Resident Council meeting minutes and Resident clinical health care records.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Quality Improvement**
**Recreation and Social Activities**
**Residents' Council**
**Safe and Secure Home**
**Skin and Wound Care**
**Sufficient Staffing**

**Findings of Non-Compliance were found during this inspection.**

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home is maintained at a minimum of 22 degrees Celsius.

Concerns were raised during stage 1 of the Resident Quality Inspection on September 4, 2014 during a family interview related to low air temperatures. On September 10, 2014 Resident #33 stated to Inspector #541 that he/she finds the air temperature in his/her room on the third floor cold. On September 10, 2014 a family member informed inspector that the air temperature is very cold in a resident's room on the

second floor.

It is noted there are adjustable thermostats in a number of resident rooms and common areas including the dining rooms and sunroom. Some thermostats have a locked plastic box covering them while others are open for anybody to adjust.

On September 10, 2014 Inspector #541 met with the Maintenance Manager to discuss air temperatures in the home. The Maintenance Manager was unable to show Inspector how the air temperatures in each resident room and common areas are monitored. When asked if the home has a device to measure air temperatures the Maintenance Manager did not have access to one at that time.

Inspector #541 proceeded to monitor temperatures using the wall thermostats in the following areas, with the following results:
- Room 267 thermostat in room reads 71 degrees F (21.6 degrees Celsius) on September 8, 2014
- 2nd floor sun room in resident common area thermostat reads 69 degrees F (20.5 degrees Celsius) on September 8, 2014
- Room 367 thermostat in room reads 69 degrees F (20.5 degrees Celsius) on September 10, 2014
- 2nd floor dining room thermostat reads 71 degrees F (21.6 degrees Celsius) on September 10, 2014
- 3rd floor sun room in resident common area thermostat reads 68 degrees F (20 degrees Celsius) on September 10, 2014
- Room 277 thermostat in room reads 68 degrees F (20 degrees Celsius) on September 11, 2014

On September 11, 2014 the Maintenance Manager also observed and confirmed the thermostat reading of 68 degrees F (20 degrees Celsius) in room 277.

It is noted the licensee was found to be non-compliant with O. Reg 79/10 s. 21 on November 4, 2013 and was issued a Voluntary Plan of Correction. [s. 21.]

***Additional Required Actions:***

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

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement**
**Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:**
**1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.**
**2. The system must be ongoing and interdisciplinary.**
**3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents’ Council, Family Council and the staff of the home on an ongoing basis.**
**4. A record must be maintained by the licensee setting out,**
**i. the matters referred to in paragraph 3,**
**ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and**
**iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.**

**Findings/Faits saillants :**

The licensee has failed to comply with O.Reg 79/10 s. 228 whereby the licensee did not ensure that the quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home, required under section 84 of the Act, complies with the following requirements:

1. Provides a written description of its goals, objectives, policies, procedures and protocols, and a process to identify initiatives for review.
2. The system is ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Resident's Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out, ii. the names of the persons who participated in evaluations, and the dates improvements were implemented.

As per LTCHA, 2007 s.84 Every licensee of a long-term care home shall develop and

implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home.

On September 3, 2014 the Administrator completed the Quality Improvement LTCH Licensee Confirmation Checklist for Quality Improvement and indicated that quality improvement and utilization review system does not provide a written description of its goals, objectives, policies, procedures and protocols, and a process to identify initiatives for review; the QI and utilization review system is not ongoing and interdisciplinary; the licensee does not maintain a record setting out the improvements made to the quality of the accommodation, care, services, programs and goods provided to residents and that the home does not maintain a record of the names of the persons who participated in evaluations and the dates improvements were implemented.

On September 8, 2014 the Administrator confirmed this information with Inspector 143.

In addition, the following non-compliances were noted during the inspection:
-the skin and wound care program does not have a written description that includes goals and
objectives and the program is not evaluated annually (Refer to WN #5)
-The annual evaluation of the medication management system was not interdisciplinary as it did not include the Administrator or the Registered Dietitian of the home (See WN #8) [s. 228.]

***Additional Required Actions:***

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

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**WN #3: 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. (2) The licensee shall ensure,**
**(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program; O. Reg. 79/10, s. 229 (2).**
**(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).**
**(c) that the local medical officer of health is invited to the meetings; O. Reg. 79/10, s. 229 (2).**
**(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).**
**(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).**

**s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:**
**1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).**

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

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**Findings/Faits saillants :**

1. On September 11, 2014 Inspector #143 met with the DOC and Charge RN. The DOC informed the inspector that licensee had purchased infection control policies and procedures in May of 2014. The DOC informed the inspector that the home had not implemented any of the policies and procedures. The DOC advised the inspector that the home does not have an infection control committee and that the program has not been evaluated at least annually. The inspector was advised that the a designated staff member had been identified to co-ordinate the program but as of yet had not completed additional training in infection prevention and control practices. The DOC advised the inspector that the the local medical officer of health has not been invited to any meetings as the home has not had any meetings. [s. 229. (2)]

2. The licensee has failed to ensure that all residents that admitted to the home are screened for tuberculosis within 14 days of admission.

On September 1, 2014 Inspector #143 met with the day Charge RN.   This staff member provided the inspector a list of residents that were admitted since February 10th, 2014. On February 10th, 2014 the homes immunization fridge was taken out of service in response to its inability to maintain temperatures between 2 degrees Celcius to 8 degrees Celcius.  The Local Public Health Unit has required the home to maintain daily recordings of the immunization fridge temperatures. From February 10th to August 14th, 2014 inclusive the home has not maintained daily recordings of the immunization fridge and as such as not been able to provide any newly admitted residents with TB immunization.  Twelve resident immunizations records were reviewed of which two recently had chest xrays.  Staff member #S100 was not able to verify if any of the residents had TB or had been exposed to TB.  Staff member #S100 informed the inspector that the home currently is not screening residents for TB. [s. 229. (10) 1.]

3. The licensee has failed to ensure that residents are offered immunization against tetanus and diphtheria (Td).
On September 12, 2014 RN Staff member #S100 provided Inspector #143 with the immunization records for twelve recently admitted residents.  A review of resident # 47, #48 and resident #49 immunizations records indicated that a tetanus and diphtheria vaccine had not been offered and staff member #S100 was unsure when these three residents' last had a Td vaccine administered. Staff member #S100 reported to the inspector that the home does not provide immunization against Td. [s. 229. (10) 3.]

***Additional Required Actions:***

***CO # - 003 will be served on the licensee. Refer to the “Order(s) of the Inspector”.***
***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents admitted to the home are screened for tuberculosis within 14 days of admission and that residents are offered immunization against tetanus and diphtheria (TD), to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

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

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**Findings/Faits saillants :**

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

The following observations were made by Inspectors #572, 541 and 548 during the inspection period:

First floor:
Room 151 - Bottom of walls and walls around doorway have marked and chipped areas
Room 155 - Chipped paint in areas along lower wall
Room 159 - Lower areas of walls have marks and chips

Common areas - Crack in floor of tub room approximately 3 cm x 6 cm. Patched areas on walls not yet painted

Second floor:
Room 252 - Wall behind resident's bed, wall in resident's bathroom and wall in front of resident's bed has many gauges
Room 266 - Wall to the left of resident's door has many gauges
Room 269 - Large strip of drywall in disrepair beside resident's bed
Room 275 - Lower wall behind resident's bed and wall on the way into room is in disrepair

Third floor:
Room 371 - Floor in bathroom is discolored in large area
Room 367 - Scuff marks and pitting in gyprock
Room 360 - Scuff marks on wall in resident's room
Room 353 - Black markings and scuff marks on wall in resident's room. Large amount of dead insects and spider webs behind window screen in resident's room
Room 364 - Scuff marks and pitting in gyprock by resident's bed
Room 358 - Scuff marks and pitting in gyprock on wall leading to bathroom and inside bathroom wall [s. 15. (2) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.***

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

**Specifically failed to comply with the following:**

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

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

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**Findings/Faits saillants :**

1. The licensee has failed to ensure that a written staffing plan for the nursing and personal support services program is in place.

During the period of October 8-10, 2014 two residents and one family member reported that there is insufficient staff to meet residents needs. A letter was received by Inspector #541 reporting that the home worked short the weekend of August 29-31st 2014. On September 11th, 2014 Inspector #143 met with the Administrator and DOC. The Administrator reported that the home does not have a written staffing plan in place. [s. 31. (2)]

2. The licensee has failed to ensure that the staffing plan includes a back up plan for staffing that addresses situations when staff cannot come to work as well that the staffing plan is evaluated at least annually.
On September 11th, 2014 Inspector #143 met with the Administrator and DOC. The administrator reported to the inspector that the home does not have a staffing plan or a back up plan that addresses situations when staff cannot come to work. The Administrator identified that home has had insufficent staffing levels related to staff abseentism. The Administrator identifed that during a recent outbreak staffing levels were less then scheduled related to staff illnesses, lack of agency staff and staff immunizations. The Administrator reported that the back up plan is informal and routines are adjusted to best meet resident needs. Reports that as part of an informal back up plan one additional staff is provided on weekends when staff abseentism is problematic. The Administrator reported to the inspector that the home does not complete a comprehensive review annually of staffing. [s. 31. (3)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a written staffing plan for the nursing and personal support services program is in place, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal**

**Specifically failed to comply with the following:**

**s. 136. (3) The drugs must be destroyed by a team acting together and composed of,**
**(b) in every other case,**
**(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and**
**(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).**

**s. 136. (4) Where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy must provide that the team composed of the persons referred to in clause (3) (a) shall document the following in the drug record:**
**1. The date of removal of the drug from the drug storage area. O. Reg. 79/10, s. 136 (4).**
**2. The name of the resident for whom the drug was prescribed, where applicable. O. Reg. 79/10, s. 136 (4).**
**3. The prescription number of the drug, where applicable. O. Reg. 79/10, s. 136 (4).**
**4. The drug's name, strength and quantity. O. Reg. 79/10, s. 136 (4).**
**5. The reason for destruction. O. Reg. 79/10, s. 136 (4).**
**6. The date when the drug was destroyed. O. Reg. 79/10, s. 136 (4).**
**7. The names of the members of the team who destroyed the drug. O. Reg. 79/10, s. 136 (4).**
**8. The manner of destruction of the drug. O. Reg. 79/10, s. 136 (4).**

**s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).**

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**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg. 79/10, s. 136(3)(b) whereby the licensee did not ensure that where a drug to be destroyed is not a controlled substance, it will be done by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of Nursing and Personal Care.

In an interview on September 8, 2014, RN Staff #S100 described the process that the

home utilizes for Surplus Medications that are not controlled substances as per O.Reg. 79/10, s.136(6). Staff member #S100 stated that non-controlled medications are not destroyed (and thus not denatured) in the home prior to disposal by the contracted bio-hazardous waste company. On September 10, 2014, the Director of Care confirmed that when a drug to be destroyed is not a controlled substance, it is not destroyed and thus is not denatured prior to disposal by the contracted bio-hazardous waste company. [s. 136. (3) (b)]

2. The licensee has failed to comply with O. Reg. 79/10, s. 136(4)(8) whereby the licensee did not ensure that where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy must provide that the team shall document the manner of destruction of the drug in the drug record.

In an interview on September 8, 2013, RN Staff #S100 described the process that he/she and the pharmacist utilize to destroy controlled drugs, but this process was not documented. On September 10, the Director of Care confirmed that where a drug to be destroyed is a controlled substance, the destruction and disposal policy, Disposal of Surplus Medications- 3.14, does not specify that the team shall document the manner of destruction in the drug record. [s. 136. (4)]

3. The licensee has failed to comply with O. Reg. 79/10, s. 136(6) whereby the licensee did not ensure that when a drug is destroyed, it is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

In an interview on September 8, 2014, RN Staff #S100 described the process that the home utilizes for Surplus Medications that are not controlled substances. Staff member #S100 stated that non-controlled medications are not destroyed (and thus not denatured) in the home prior to disposal by the contracted bio-hazardous waste company. On September 10, 2014, the Director of Care confirmed that when a drug to be destroyed is not a controlled substance, it is not destroyed (and thus not denatured) prior to disposal by the contracted bio-hazardous waste company. [s. 136. (6)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where a drug to be destroyed is not a controlled substance, it will be done by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care and one other staff member appointed by the Director of Nursing and Personal Care, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

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

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA, 2007, s. 3 (1)(11)(iv) by not ensuring that residents' personal health information is kept confidential.

1. On September 2, 2014, the medication cart on Floor 2 was observed outside the dining room where residents were eating lunch, unattended and with the computer screen displaying residents' personal health information.

2. On September 8, 2014, RPN Staff member #105 was observed administering medications on Floor 1 in the dining room. Staff member #105 went into the dining room several times to provide a resident with medications. At these times the cart was not visible and the computer screen displayed residents' personal health information. There were residents and family members around the cart. [s. 3. (1) 11. iv.]

2. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.3 (1)(14), whereby the licensee did not ensure that every resident has the right to communicate in confidence with any person without interference.
On Sept. 2, 2014 Resident #11 stated that he/she does not have a private place to make a telephone call, since he/she does not have a telephone in his/her room. Staff member RPN #S105 and staff member RN #S100 confirmed that the Care Centre (nursing station) is the only alternative telephone available for residents in the care area and it is not private. Staff member #S110 also confirmed that the telephone at the front desk of the home may occasionally be used, but it is not private. [s. 3. (1) 14.]

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (1)(a) whereby the licensee did not ensure that the written plan of care for each resident sets out the planned care for the resident.

The most recent Care Plan for Resident #32 indicates that the resident has an ulcer. The resident requires a dressing change every 3 days.

The current electronic Treatment Administration Record does not reflect that the dressings are completed as per the Care Plan. The paper Treatment Administration Record states that the dressing is to be completed only as needed. Staff PSW #114 stated that the resident did not have a dressing in place currently.

Staff RPN # 116 stated that the inconsistencies in the plan of care result in inefficient use of time as he/she can recall when he/she has prepared supplies to change a dressing, only to find that the dressing is not required.
The written plan of care for Resident #32 does not set out the planned care for the resident. [s. 6. (1) (a)]

2. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (1)(a) whereby the licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (1)(c) whereby the licensee did not ensure that the written plan of care for each resident sets out the planned care for the resident.

The most recent Care Plan from 2014-07-29 for Resident #28 indicates that the resident has an ulcer that requires treatment. It also states that the resident has another dressing to be complete every 3-5 days.

The current electronic and paper Treatment Administration Records do not reflect that the dressings are completed as per the Care Plan. In an interview, staff RPN #116 confirmed that the resident does not require or receive a dressing.

The written plan of care for Resident #28 does not set out the planned care for the resident. [s. 6. (1) (a)]

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:**
**1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).**
**2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).**
**3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).**
**4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).**

**Findings/Faits saillants :**

1. The licensee failed to comply with O. Reg. 79/10 s. 30 (1)1 and 3 whereby the skin and wound care program that is required does not have a written description of the program that includes goals and objectives, as well as an annual evaluation in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

On Sept. 11, 2014, the Director of Care confirmed that the home does not have a written description of the skin and wound care program that includes goals and objectives. She also confirmed that the program is not evaluated annually. [s. 30. (1) 1.]

**WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council**

**Specifically failed to comply with the following:**

**s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA, 2007, s. 60 (2) whereby the licensee has not responded in writing within 10 days to any concerns or recommendations about the operation of the home by Family Council.

During a Family Council meeting on June 17, 2014, concerns were raised regarding changes in staff assignments for consistency of care, short staffing, and a new Pleasurable Dining program. The Director of Care responded to the concerns at the meeting, but a written response was not provided. On September 11, 2014 the Administrator confirmed that he does not provide any responses in writing to concerns or recommendations from the Family Council. [s. 60. (2)]

**WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey**

**Specifically failed to comply with the following:**

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

**s. 85. (4)  The licensee shall ensure that,**
**(a) the results of the survey are documented and made available to the Residents’ Council and the Family Council, if any, to seek their advice under subsection (3);  2007, c. 8, s. 85. (4).**
**(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents’ Council and the Family Council, if any;  2007, c. 8, s. 85. (4).**
**(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and  2007, c. 8, s. 85. (4).**
**(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX.  2007, c. 8, s. 85. (4).**

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**Findings/Faits saillants :**

1. The licensee has failed to ensure that the Resident Council (RC) advice is sought in developing and carrying out the satisfaction survey and acting on its results.

On September 9th, 2014 the President of RC was interviewed.  During this interview RC meetings and minutes were reviewed with the President of the RC.  A review of the minutes for 2013 and 2014 indicated that the RC advice had not been requested. On September 9th, 2014 the Administrator informed inspector #143 that he had not presented the satisfaction survey to the RC.  Staff member #S112 who attends RC as an assistant reported to Inspector #143 that the satisfaction survey nor its results are presented to the RC. [s. 85. (3)]

2. The licensee has failed to comply with LTCHA, 2007, s. 85. (3) whereby the licensee did not seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

In an interview on September 10, 2014, a member of the Family Council #F117 could not recall any discussion about the home’s satisfaction survey. On September 11, 2014 the Administrator confirmed that the licensee does not seek the advice of the

Family Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

3. The licensee has failed to ensure that the Long Term Care Homes Act section 85.4 (a) is complied with by not making the results available to the RC of the satisfaction survey.

An interview with the President of RC, the Administrator and staff member #S112 all confirmed that the satisfaction survey results are not made available to the RC. The Administrator completed the LTCH Licensee Confirmation checklist (September 3, 2014) and and indicated a no response to question #10 in respect of the satisfaction survey results. [s. 85. (4) (a)]

4. The licensee has failed to comply with LTCHA, 2007, s. 85. (4)(a) whereby the licensee did not document and make available to the Family Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

In an interview on September 10, 2014, a member of the Family Council #F117 could not recall any discussion about the home's satisfaction survey. On September 11, 2014 the Administrator confirmed that the licensee does not document and make available to the Family Council the results of the satisfaction survey. [s. 85. (4) (a)]

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**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device**

**Specifically failed to comply with the following:**

**s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:**
**7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).**

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**Findings/Faits saillants :**

1. The licensee has failed to ensure that the documentation for Resident #15 includes documentation of every release of the restraint and repositioning.

On a specified date, Inspector #541 observed Resident #15 sitting in his/her

wheelchair with a lap belt and tabletop applied. A physician's order for Resident #15 indicates he/she is to have a front closing belt and a tabletop while in wheelchair.

Resident #15 was observed by Inspector #541 on specified dates and times to have both the front closing belt and tabletop applied.

As per O.Reg. 79/10 s. 110 (2)4 where a resident is restrained by a physical device under section 31 of the Act, the following requirement must be in place: the resident is released from the physical device and repositioned at least once every two hours.

The restraint observation forms for Resident #15 were reviewed:

-On a specified date the restraint observation form indicates Resident #15 had a front closing seat belt and a tabletop applied at 1300 hrs and removed at 2100 hrs. There is no documentation that the resident was released from the device and repositioned during this time period.

-On a specified date the restraint observation form indicates Resident #15 had a front closing seat belt and a tabletop applied at 1400 hrs to 2100 hrs at which time the restraint was released. The documentation indicates Resident #15 was released from the device once during this seven hour period. The documentation does not reflect any repositioning of Resident #15.

- On a specified date the restraint observation form for Resident #15 does not reflect that he/she had a restraint applied as observed by Inspector #541 at 1138 hrs. The form has not been completed from 0600 hrs to 2100 hrs.

-On a specified date the restraint observation form indicates Resident #15 had a tabletop and front closing seat belt applied at 1400 hrs to 1800 hrs. There is no documentation that the resident was released from the device and repositioned during this 4 hour time period.

RPN staff member #S108 indicated to inspector #541 on September 10, 2014 that when a resident has a physical restraint, it is the expectation that the resident is monitored every 2 hours and the restraint is to be released. Staff member #S108 further stated it is the expectation the restraint observation form is completed every hour for the resident with a physical restraint. [s. 110. (7) 7.]

**WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation**

**Specifically failed to comply with the following:**

**s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg. 79/10, s. 115(1) whereby the licensee did not ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, and the pharmacy provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

On September 11, 2014 the Administrator and the Director of Care confirmed that the home does not have quarterly meetings to evaluate the effectiveness of the medication management system. [s. 115. (1)]

**WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation**

**Specifically failed to comply with the following:**

**s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg. 79/10, s. 116(1) whereby the licensee did not ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy provider, and a Registered Dietitian who is a member of the staff of the home meets at least annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

In an interview on September 10, 2014 the Director of Care provided the documentation from the Annual Pharmacy review for the home on December 5, 2013; it included the Pharmacist, Director of Care, and Medical Director.
On September 11, 2014 the Administrator and the Director of Care confirmed that that the interdisciplinary team that completed the annual review of the medication management system did not include the Administrator and a Registered Dietitian from the home. [s. 116. (1)]

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**WN #15: 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).**

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**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg. 79/10, s. 129 (1)(a)(ii) whereby the licensee did not ensure that drugs stored in a medication cart were not kept secure and locked.

1. On September 2, 2014, the medication cart on Floor 2 was observed unattended and unlocked for approximately 10 minutes outside the dining room where residents were eating lunch.

2. On September 3, 2014, Inspector #548 observed RPN Staff member #S102 administering medications on Floor 3 in the dining room. The medication cart was not visible outside the room and was unlocked. Staff member #S102 stated that it was the home's policy to lock the cart when unattended, but he/she thought he/she had locked it.

3. On September 8, 2014, RPN Staff member #S105 was observed administering medications on Floor 1 in the dining room. Staff member #S105 went into the dining room several times to provide a resident with medications. At these times the cart was not visible and it was left unlocked. There were residents and family members around the cart. [s. 129. (1) (a)]

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**Issued on this 21st day of October, 2014**

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

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

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

## Public Copy/Copie du public

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | AMBER MOASE (541), BARBARA ROBINSON (572), PAUL MILLER (143) |
| **Inspection No. / No de l'inspection :** | 2014_280541_0030 |
| **Log No. / Registre no:** | O-000866-14 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Oct 17, 2014 |
| **Licensee / Titulaire de permis :** | TRENT VALLEY LODGE LIMITED<br>195 Bay Street, TRENTON, ON, K8V-1H6 |
| **LTC Home / Foyer de SLD :** | TRENT VALLEY LODGE LIMITED<br>195 BAY STREET, TRENTON, ON, K8V-1H9 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | BILL WEAVER JR |

To TRENT VALLEY LODGE LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan to ensure the home is maintained at a minimum temperature of 22 degrees Celsius. The plan shall include the process to continually monitor the home's air temperatures.

This plan must be submitted in writing to Inspector, Amber Moase at 347 Preston Street, 4th floor, Ottawa, ON K1S 3J4 or by fax at 1-613-569-9670 on or before October 24, 2014.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the home is maintained at a minimum of 22 degrees Celsius.

Concerns were raised during stage 1 of the Resident Quality Inspection on September 4, 2014 during a family interview related to low air temperatures. On September 10, 2014 Resident #33 stated to Inspector #541 that he finds the air temperature in his room on the third floor cold. On September 10, 2014 a family member informed inspector that the air temperature is very cold in a resident's room on the second floor.

It is noted there are adjustable thermostats in a number of resident rooms and common areas including the dining rooms and sunroom. Some thermostats have a locked plastic box covering them while others are open for anybody to adjust.

On September 10, 2014 Inspector #541 met with the Maintenance Manager to discuss air temperatures in the home. The Maintenance Manager was unable to show the Inspector how the air temperatures in each resident room and common

areas are monitored. When asked if the home has a device to measure air temperatures the Maintenance Manager did not have access to one at that time.

Inspector #541 proceeded to monitor temperatures using the wall thermostats in the following areas, with the following results:
- Room 267 thermostat in room reads 71 degrees F (21.6 degrees Celsius) on September 8, 2014
- 2nd floor sun room in resident common area thermostat reads 69 degrees F (20.5 degrees Celsius) on September 8, 2014
- Room 367 thermostat in room reads 69 degrees F (20.5 degrees Celsius) on September 10, 2014
- 2nd floor dining room thermostat reads 71 degrees F (21.6 degrees Celsius) on September 10, 2014
- 3rd floor sun room in resident common area thermostat reads 68 degrees F (20 degrees Celsius) on September 10, 2014
- Room 277 thermostat in room reads 68 degrees F (20 degrees Celsius) on September 11, 2014

On September 11, 2014 the Maintenance Manager also observed and confirmed the thermostat reading of 68 degrees F (20 degrees Celsius) in room 277.

It is noted the licensee was found to be non-compliant with O. Reg 79/10 s. 21 on November 4, 2013 and was issued a Voluntary Plan of Correction. (541)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Nov 28, 2014

**Order # / Ordre no :** 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 228. Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan to ensure that the quality improvement and utilization review system complies with the following requirements:
1. Provides a written description of its goals, objectives, policies, procedures and protocols, and a process to identify initiatives for review.
2. The system is ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Resident's Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out, ii. the names of the persons who participated in evaluations, and the dates improvements were implemented.

The plan shall also indentify timelines for implementing the system and the names of the individuals involved in the implementation.

This plan must be submitted in writing to Inspector, Amber Moase at 347 Preston Street, 4th Floor, Ottawa ON K1S 3J4 or by fax at 1-613-569-9670 on or before October 24, 2014.

**Grounds / Motifs :**

1. The licensee has failed to comply with O.Reg 79/10 s. 228 whereby the licensee did not ensure that the quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home, required under section 84 of the Act complies with the following requirements:

1. Provides a written description of its goals, objectives, policies, procedures and protocols, and a process to identify initiatives for review.
2. The system is ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Resident's Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out, ii. the names of the persons who participated in evaluations, and the dates improvements were implemented.

On September 3, 2014 the Administrator completed the Quality Improvement LTCH Licensee Confirmation Checklist for Quality Improvement (QI) and indicated the quality improvement and utilization review system does not provide a written description of its goals, objectives, policies, procedures and protocols, and a process to identify initiatives for review; the QI and utilization review system is not ongoing and interdisciplinary; the licensee does not maintain a record setting out the improvements made to the quality of the accommodation, care, services, programs and goods provided to residents and that the home does not maintain a record of the names of the persons who participated in evaluations and the dates improvements were implemented.

On September 8, 2014 the Administrator confirmed this information with Inspector 143.

As per LTCHA, 2007 s.84 Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home.

In addition, the following non-compliances were noted during the inspection:
-the Skin and Wound Care program does not have a written description that includes goals and
objectives and the program is not evaluated annually (Refer to WN #5)
-The annual evaluation of the medication management system was not interdisciplinary as it did not include the Administrator or the Registered Dietitian of the home (See WN #8) (541)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jan 19, 2015

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
(c) that the local medical officer of health is invited to the meetings;
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that:
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the infection prevention and control program; (b) that the interdisciplinary team that co-ordinates and implements the infection prevention and control program meets at least quarterly; (c) that the local medical officer of health is invited to the meetings; (d) that the infection prevention and control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and (e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

This plan must be submitted in writing to Inspector, Amber Moase at 347 Preston Street, 4th floor, Ottawa, ON K1S 3J4 or by fax at 1-613-569-9670 on or before October 24, 2014.

**Grounds / Motifs :**

1. On September 11, 2014 Inspector #143 met with the DOC and Charge RN. The DOC informed the inspector that licensee had purchased infection control policies and procedures in May of 2014. The DOC informed the inspector that the home had not implemented any of the policies and procedures. The DOC advised the inspector that the home does not have an infection control committee and that the program has not been evaluated at least annually. The inspector was advised that a designated staff member had been identified to co-ordinate the program but as of yet had not completed additional training in infection prevention and control practices. The DOC advised the inspector that the the local medical officer of health has not been invited to any meetings as the home has not had any meetings.  The DOC also advised the inspector that the home has not completed an annual evaluation of the infection control program. (143)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jan 19, 2015

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board  and the Director

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

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

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

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

**Issued on this 17th day of October, 2014**

**Signature of Inspector / Signature de l'inspecteur :**

**Name of Inspector / Nom de l'inspecteur :** Amber Moase

**Service Area Office / Bureau régional de services :** Ottawa Service Area Office