Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 9, 2018	2017_491647_0021	028245-17	Resident Quality Inspection

Licensee/Titulaire de permis

JARLETTE LTD.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

THE VILLA CARE CENTRE
689 YONGE STREET MIDLAND ON L4R 2E1

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

JENNIFER BROWN (647), JUDITH HART (513)

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): December 11, 12, 13, 14, 19, 20, 21, 2017, January 8, 9, 10, 11, 2018.

The following critical incidents were inspected concurrently with this inspection:
#025810-16 related to fall prevention and management
#027876-16 related to plan of care
#003542-17 related to responsive behaviours
#009535-17 related to plan of care

The following complaints were inspected concurrently with this inspection:
#031016-16 related to transferring and positioning techniques
#029763-16 related to dining and snack service, residents' bill of rights, and plan of care

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Co-Director of Care (CoDOC), Resident and Family Services coordinator, Restorative Care coordinator, Volunteer coordinator, Dietary Manager, Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), Dietary Aides, Community Support Worker, Families, Substitute Decision Makers and Residents.

During the course of the inspection, the inspectors conducted observation in home and resident areas, observation of care delivery processes including medication administration, meal delivery services, and review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint on an identified date and identified resident, relating to a lower extremity injury.

A review of the written plan of care on an identified date, revealed an identified resident was independent with an identified activity of daily living. The identified resident required assistance to go from floor to floor.

The minimum data set (MDS) for an identified date, revealed the identified resident required one-person assistance for locomotion off the unit. There was no direction identified in the written plan of care regarding the use of an assistive device when staff were assisting the resident with locomotion for long distances.

A review of the progress notes for an identified date, revealed the identified resident was returning to his/her home area, being assisted by direct care staff member #123. Direct care staff member #123 reported that while assisting the identified resident, his/her lower extremity dropped suddenly to the floor. The registered staff were called and no injury was found. The following day the direct care staff member that was providing care on that day observed signs of injury to the lower extremity and reported this to the registered staff. The resident was assessed, sent to hospital, diagnosed with a lower extremity injury and returned to the home on an identified date. The written plan of care was updated to include medical and transferring interventions.

An interview on an identified date, with direct care staff member #123 revealed on an identified date, the resident was being assisted back to the resident's care area when the resident's lower extremity dropped suddenly. This had not happened previously. The resident was asked if he/she had any pain and stated his/her lower extremity hurt. The registered staff were called and assessed the resident.

An interview on an identified date, with Registered staff member #122 revealed the resident was being assisted back to the resident's care area when the resident's lower extremity dropped suddenly. The resident was assessed of no injury and which ultimately resulted in the diagnosis of a lower extremity injury. It was revealed there was no direction identified in the written plan of care regarding the use of the assistive device when staff were assisting the resident with locomotion for long distances.

On an identified date, an interview with the Co Director of Care (CoDOC) confirmed during resident #016's injury, there was no clear direction identified in the written plan of care regarding the use of the assistive devices when staff were assisting the resident with locomotion off the unit or for long distances. [s. 6. (1) (c)]

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

The home submitted a CI on an identified date, indicating that resident #008 had been transferred to hospital and later diagnosed with a lower extremity injury.

A review of the CI mentioned above indicated that on an identified date, resident #008 had been assisted to the washroom at an identified time by staff, had been assisted back to bed, and had been later found on the floor beside his/her bed.

A review of the clinical records indicated that resident #008 was able to utilize an assistive device to mobilize in bed and pull himself/herself over using this assistive device to assist in care.

A review of the written plan of care at the time of the incident indicated that the assistive device is to be used by resident during care to assist in mobility while in bed and then the assistive device is to be removed once the care is completed.

A review of the progress notes of the incident indicated that when resident #008 had

been found on the floor, he/she had been found with his/her arm gripped to the assistive device as it had not been removed after the care had been provided as per the directions in the plan of care.

During an interview with resident #008, he/she indicated that he/she did remember the fall and verified that he/she uses the assistive device to assist staff with care.

An interview with direct care staff member, indicated that he/she had been responsible for the care of resident #008 during the time of the above mentioned incident, and confirmed that after he/she assisted resident #008 back to bed after using the washroom, he/she had left the assistive device in place.

Direct care staff member acknowledged during the interview that it had been in the resident's plan of care to lower the assistive device after care is received and as a result of the assistive device not being lowered, resident #008 had been able to use it to attempt to self-transfer resulting in the fall. Direct care staff member #108 further acknowledged that resident had the arm strength to use the assistive device to get out of the bed.

Registered staff member #107 indicated during an interview that resident #008 had been a risk for falls and at the time of the above incident had observed the assistive device in place. Registered staff member #107 further confirmed that the plan of care for resident #008 was to lower the assistive device after care due to this risk.

An interview with the DOC confirmed that the plan of care for resident #008 had not been followed when the assistive device had not been lowered after care placing resident at risk for using the assistive device to self-transfer. [s. 6. (7)]

3. A complaint was received on an identified date, indicating resident #016 had not been served fluids at a safe temperature. The resident was reported to have sustained an injury to his/her lower extremities after spilling his/her coffee.

A review of the progress notes for an identified date, revealed the resident spilled hot tea on his/her lower extremity, causing possible injury. A subsequent note on an identified date, revealed no injury from resident spilling tea. A progress note for another identified date, identified a treatment was performed to an identified area. A dietary assessment identified no adaptive devices were required. A dietary assessment identified the resident was unsteady when holding a mug in hand and the Nutrition Manager initiated a lid on

the mug, which was also included in the written plan of care.

Observations during the identified inspection period, revealed resident #016 was served coffee with milk product and there was no lid placed on the cup. A moderate to large coffee stain was observed on the resident's clothing protector.

Volunteer Coordinator #127 confirmed the resident did not have a lid on the mug and had a moderate to large coffee stain on his/her clothing protector. The Master Diet List had been reviewed and it had been verified the resident was to receive a lid on a mug.

A compliance order will be served to the home based on the scope, which is isolated, and the severity of the non-compliance was actual harm to resident's #008 and #016, and the home had previously been issued for LTCHA, 2007 S.O. 2007, c.8, s.6(7) as a voluntary plan of correction (VPC) as part of inspection 2016_414110_0005 on April 18, 2016, as part of inspection 2015_334565_0011 on June 2, 2015, and also as part of inspection 2015_297558_0009 on May 19, 2015, for this legislation. [s. 6. (7)]

Additional Required Actions:

CO # - 001, 002 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the act or regulation requires the licensee of a

long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedures strategy or system is complied with.

Ontario Regulation 79/10, s. 49 requires the licensee to have a falls prevention and management program that must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

The home submitted a CI on an identified date, indicating that resident #008 had been transferred to hospital and later diagnosed with a lower extremity injury. A review of the CI mentioned above indicated that on an identified date, resident #008 had been assisted to the washroom at an identified time by staff, had been assisted back to bed, and had been later found on the floor beside his/her bed.

Review of home's policy titled "Resident Rights, Care and Services – Required Programs – Falls Preventions and Management – Program", revised May 27, 2016, revealed that a root cause analysis is to be completed and documented related to any fall that results in a fracture within the home.

An interview with the DOC indicated that a root cause analysis had not been completed following resident #008's fall that had resulted in a lower extremity injury.

Review of home's policy titled "Resident Rights, Care and Services – Required Programs – High Risk Rounds", revised August 21, 2017, revealed that there was to be a review of residents identified as having potential or actual risk including falls during a meeting on resident's unit and involving all appropriate disciplines.

An interview with the DOC indicated that resident #008, had not been discussed during the above mentioned required meeting as resident #008 had been omitted from being added to the list. [s. 8. (1) (a),s. 8. (1) (b)]

2. The MOHLTC received a complaint on an identified date, related to resident #016's fall.

Review of home's policy titled, Resident Rights, Care and Services; Required Programs; Falls Preventions and Management Program; Revised May 27, 2016, revealed that a fall

follow-up progress note is to be completed for at least three shifts following a fall incident.

A review of the progress notes on an identified date, identified resident #016, slipped, unwitnessed, off the side of the bed to the floor without injury. It was reported that perhaps the resident was trying to self-transfer. A bed alarm and lo-bed were subsequently placed for the resident's use. No other follow-up notes were documented including the three follow-up progress notes, as per policy.

An interview with Registered staff #124 revealed a post falls follow-up progress note was completed for the shift immediately after the fall. No other follow-up note was documented and therefore, three follow-up progress notes were not completed.

An interview with the Co-Director of Care (CoDOC) confirmed three follow-up progress notes were not completed as required by policy. [s. 8. (1) (a),s. 8. (1) (b)]

3. The following medication incident for resident #015 was reviewed on an identified date for an identified medication. The medication was administered at another time other than prescribed without adverse effects.

Record review of the home's policy titled, Resident Rights, Care and Services-Medication Management-Medication Incident," Version 2, Revised Date July 20, 2017, which states, "upon identification of a medication error, the individual identifying the error will notify/report the identified medication error to the resident/resident's SDM of the medication incident.

A review of the Medication Incident Report revealed that the aforementioned medication was administered at another time other than prescribed.

A review of the progress notes for the above mentioned medication error did not indicate that the SDM had been informed of the error.

An interview with Registered staff member #110 revealed the aforementioned medication was administered at another time other than prescribed. The error was immediately noted and reported to nursing and medical personnel, however the resident's SDM was not notified.

An interview with the CoDOC confirmed that the home's expectation was for registered

staff to notify the resident's SDM of the medication error. [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On an identified date, during the RQI mandatory inspection of medication administration the Medication Incident summary reports and individual Medication Incident Reports were reviewed. The following medication incident for resident #015 was reviewed, and had been administered at another time other than prescribed without adverse effects.

An interview with Registered staff member #110 revealed during medication administration on an identified date, resident #015's received an identified medication at a different time other than prescribed as the medication pouch was opened by accident due to distraction during medication administration. The Registered staff member revealed the medication was not administered in accordance with the directions for use specified by the prescriber.

An interview with the DOC confirmed the identified medication for resident #015 was not administered in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction is:
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

On an identified date, during the RQI mandatory inspection of medication administration the Medication Incident summary reports and individual Medication Incident Reports were reviewed. The following medication incident for resident #015 was reviewed, and had been administered at another time other than prescribed without adverse effects.

The Medication Administration Record was reviewed and revealed the medication was signed off by Registered staff member #110 for an identified time. The following dose was documented by Registered staff member #128 as #7 which had indicated the resident had been sleeping.

An interview with Registered staff member #110 revealed during medication administration on an identified date, resident #015's identified medication was administered at a different time other than prescribed as the medication pouch was opened by accident due to distraction during medication administration. Registered staff member #110 further revealed that he/she could not recall informing the family or Substitute Decision Maker (SDM) and there was no notation regarding notifying the SDM in the progress notes.

An interview with the DOC confirmed the nurse who administered the medication had no recollection of the SDM being notified, nor was there documentation to substantiate the SDM had been notified for the above medication error. [s. 135. (1)]

Issued on this 13th day of February, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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) :	JENNIFER BROWN (647), JUDITH HART (513)
Inspection No. / No de l'inspection :	2017_491647_0021
Log No. / No de registre :	028245-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 9, 2018
Licensee / Titulaire de permis :	JARLETTE LTD. c/o Jarlette Health Services, 5 Beck Boulevard, PENETANGUISHENE, ON, L9M-1C1
LTC Home / Foyer de SLD :	THE VILLA CARE CENTRE 689 YONGE STREET, MIDLAND, ON, L4R-2E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Stephanie Walpole

To JARLETTE LTD., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with c. 8, s. 6(1)(c). Specifically, the licensee will prepare, submit and implement a plan to ensure that staff are provided clear direction and other who provide direct care to residents.

The plan will include, but is not limited to the following:

A revision of resident #016's written plan of care to reflect the resident's ambulation, transferring, and Activities of Daily Living (ADL) needs.

A review of the revised written plan of care with all direct care staff responsible for resident #016's care.

The plan is to be submitted to jennifer.brown6@ontario.ca by February 23, 2018.

Grounds / Motifs :

1. The licensee failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint on an identified date and identified resident, relating to a lower extremity injury.

A review of the written plan of care on an identified date, revealed an identified resident was independent with an identified activity of daily living. The identified resident required assistance to go from floor to floor.

The minimum data set (MDS) for an identified date, revealed the identified resident required one-person assistance for locomotion off the unit. There was no direction identified in the written plan of care regarding the use of an assistive device when staff were assisting the resident with locomotion for long distances.

A review of the progress notes for an identified date, revealed the identified resident was returning to his/her home area, being assisted by direct care staff member #123. Direct care staff member #123 reported that while assisting the identified resident, his/her lower extremity dropped suddenly to the floor. The registered staff were called and no injury was found. The following day the direct care staff member that was providing care on that day observed signs of injury to the lower extremity and reported this to the registered staff. The resident was assessed, sent to hospital, diagnosed with a lower extremity injury and returned to the home on an identified date. The written plan of care was updated to include medical and transferring interventions.

An interview on an identified date, with direct care staff member #123 revealed on an identified date, the resident was being assisted back to the resident's care area when the resident's lower extremity dropped suddenly. This had not happened previously. The resident was asked if he/she had any pain and stated his/her lower extremity hurt. The registered staff were called and assessed the resident.

An interview on an identified date, with Registered staff member #122 revealed the resident was being assisted back to the resident's care area when the resident's lower extremity dropped suddenly. The resident was assessed of no injury and which ultimately resulted in the diagnosis of a lower extremity injury. It was revealed there was no direction identified in the written plan of care regarding the use of the assistive device when staff were assisting the resident with locomotion for long distances.

On an identified date, an interview with the Co Director of Care (CoDOC) confirmed during resident #016's injury, there was no clear direction identified in the written plan of care regarding the use of the assistive devices when staff were assisting the resident with locomotion off the unit or for long distances. [s. 6. (1) (c)] (513)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 09, 2018

Order # / Ordre no : 002

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

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 c. 8, s. 6(7). Specifically, the licensee will prepare, submit and implement a plan to ensure that care set out in the plan of care is provided to the resident as specified in the plan.

The plan will include, but is not limited to the following:

A review of resident's #008 and #016, plan of care with all direct care staff responsible for resident's #008 and #016 care.

Develop an auditing system to ensure that all staff provide the care set out in the plan of care to resident's #008 and #016.

The plan is to be submitted to jennifer.brown6@ontario.ca by February 23, 2018.

Grounds / Motifs :

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

The home submitted a CI on an identified date, indicating that resident #008 had been transferred to hospital and later diagnosed with a lower extremity injury.

A review of the CI mentioned above indicated that on an identified date, resident #008 had been assisted to the washroom at an identified time by staff, had been assisted back to bed, and had been later found on the floor beside his/her bed.

A review of the clinical records indicated that resident #008 was able to utilize an

assistive device to mobilize in bed and pull himself/herself over using this assistive device to assist in care.

A review of the written plan of care at the time of the incident indicated that the assistive device is to be used by resident during care to assist in mobility while in bed and then the assistive device is to be removed once the care is completed.

A review of the progress notes of the incident indicated that when resident #008 had been found on the floor, he/she had been found with his/her arm gripped to the assistive device as it had not been removed after the care had been provided as per the directions in the plan of care.

During an interview with resident #008, he/she indicated that he/she did remember the fall and verified that he/she uses the assistive device to assist staff with care.

An interview with direct care staff member, indicated that he/she had been responsible for the care of resident #008 during the time of the above mentioned incident, and confirmed that after he/she assisted resident #008 back to bed after using the washroom, he/she had left the assistive device in place.

Direct care staff member acknowledged during the interview that it had been in the resident's plan of care to lower the assistive device after care is received and as a result of the assistive device not being lowered, resident #008 had been able to use it to attempt to self-transfer resulting in the fall. Direct care staff member #108 further acknowledged that resident had the arm strength to use the assistive device to get out of the bed.

Registered staff member #107 indicated during an interview that resident #008 had been a risk for falls and at the time of the above incident had observed the assistive device in place. Registered staff member #107 further confirmed that the plan of care for resident #008 was to lower the assistive device after care due to this risk.

An interview with the DOC confirmed that the plan of care for resident #008 had not been followed when the assistive device had not been lowered after care placing resident at risk for using the assistive device to self-transfer. [s. 6. (7)]

2. A complaint was received on an identified date, indicating resident #016 had

not been served fluids at a safe temperature. The resident was reported to have sustained an injury to his/her lower extremities after spilling his/her coffee.

A review of the progress notes for an identified date, revealed the resident spilled hot tea on his/her lower extremity, causing possible injury. A subsequent note on an identified date, revealed no injury from resident spilling tea. A progress note for another identified date, identified a treatment was performed to an identified area. A dietary assessment identified no adaptive devices were required. A dietary assessment identified the resident was unsteady when holding a mug in hand and the Nutrition Manager initiated a lid on the mug, which was also included in the written plan of care.

Observations during the identified inspection period, revealed resident #016 was served coffee with milk product and there was no lid placed on the cup. A moderate to large coffee stain was observed on the resident's clothing protector.

Volunteer Coordinator #127 confirmed the resident did not have a lid on the mug and had a moderate to large coffee stain on his/her clothing protector. The Master Diet List had been reviewed and it had been verified the resident was to receive a lid on a mug.

A compliance order will be served to the home based on the scope, which is isolated, and the severity of the non-compliance was actual harm to resident's #008 and #016, and the home had previously been issued for LTCHA, 2007 S.O. 2007, c.8, s.6(7) as a voluntary plan of correction (VPC) as part of inspection 2016_414110_0005 on April 18, 2016, as part of inspection 2015_334565_0011 on June 2, 2015, and also as part of inspection 2015_297558_0009 on May 19, 2015, for this legislation. [s. 6. (7)]
(647)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 09, 2018

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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 9th day of February, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Brown

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