Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 3, 2014	2014_281542_0014	S-000221-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE LADY MINTO HOSPITAL AT COCHRANE
241 EIGHTH STREET, P.O. BOX 4000, COCHRANE, ON, P0L-1C0

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

VILLA MINTO
241 EIGHTH STREET, P.O. BOX 280, COCHRANE, ON, P0L-1C0

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

JENNIFER LAURICELLA (542), VALA MONESTIMEBELTER (580)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 26, 27, 28, 29, June 2, 3, 4, 5, 2014

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nursing Staff, Dietary Staff, Registered Dietitian, Personal Support Workers (PSWs), Restorative Care Staff, Physiotherapy Staff, RAI Coordinator, Recreation/Volunteer Coordinator, Housekeeping Staff, Residents and Family Members.

During the course of the inspection, the inspector(s) conducted a daily walk through of resident home areas, observed staff to resident interactions, reviewed health care records and various policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
3. Every resident has the right not to be neglected by the licensee or staff. 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:
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every resident is protected from neglect.
Over the course of the inspection, Inspectors observed resident # 4 sitting in their wheelchair for most of the day and early evening. Resident # 4 was not observed to be involved in any type of activity throughout the duration of the inspection. Resident # 4 also presented with responsive behaviours. Occasionally the staff were observed offering resident # 4 something to drink or moving their wheel chair to a different location. Inspectors did not observe the resident to be partaking in any of the meals in the dining room. Resident # 4 is dependent on staff for activities of daily living, for example eating, dressing etc.
On May 29th, 2014 Inspector 542 reviewed resident # 4's health care record. It was noted on the Activity Participation Record and in the notes section of Mede-care that the resident had only been brought to or provided with one activity over a 5 month period. Inspector was informed by the Recreation/Volunteer Coordinator that the Activity Participation Record along with the notes in Mede-care is where the attendance or refusal for each resident is documented. The Recreation/Volunteer Coordinator also informed the Inspector that resident # 4 likes to attend church, music activities and conversing/reminiscing.
On June 2, 2014 Inspector 542 reviewed resident # 4's health care record pertaining to nutrition and hydration. Inspector noted that over a 7 month period there was no documentation indicating that resident # 4 was receiving any food intake. Inspector also reviewed the seating plan for the dining room meal service and noted resident # 4 was not assigned a seat at a table. The Personal Support Workers (PSWs) complete a form called the "Daily Intake Tracker" after all meals for each resident, however resident # 4 was not listed as one of the residents they monitor for daily nutritional

intake. The Registered staff keep a record of the amount of the nutritional supplement resident # 4 is consuming on another document titled, "Nutritional Intake Record." This document also identified that resident # 4's meal location is not in the dining room. Inspector interviewed several PSW staff members and was informed that resident # 4 at times will consume, yogurt, mashed potatoes, and bananas. Inspector interviewed the Registered Dietitian (RD) and was informed that the resident does not consume anything solid and that they typically only consume fluids. The documentation only supports that resident # 4 is consuming some of the ordered nutritional supplements and no other fluids. The RD stated that the resident has been like this for quite some time and does not believe any interventions have been tried in an attempt to have the resident consume solid foods. On June 4, 2014 Inspector observed resident # 4 for 45 minutes after the lunch service. Inspector interviewed two PSWs at separate times and asked them if this resident was offered lunch, both PSWs stated that the resident was not offered lunch as they typically do not eat. On June 4th, 2014 Inspector had a brief conversation with the ADOC and Inspector expressed concerns with regards to resident # 4. ADOC informed Inspector that the RD was going to put something in place today to ensure that resident is being offered 3 meals daily. On June 4th, Inspector reviewed the note from the RD, which stated that staff are to offer the meal choice prior to providing resident with a supplement and if resident refuses to eat, document it, then document how many/much of the supplement the resident consumed, track fluids consumed (regular fluids) under the fluids portion of the chart.

On June 5th, 2014 Inspector reviewed resident # 4's health care record and was unable to locate any type of behavioural assessment or reassessment other than a report from 2010 indicating that the resident was assessed by a geriatric physician and several recommendations were made. Inspector was informed by registered staff # 113 that none of the recommendations were trialled. Inspector interviewed registered staff member # 112 and was informed that resident # 4 has not been reassessed for approximately 2-3 years with regards to their responsive behaviours. In 2011, resident was started on a new medication at 2000, this medication was discontinued in November 2012. Currently, when resident # 4 displays responsive behaviours, the registered staff provide a different medication four times/day when required. Registered staff # 113 told the Inspector that they did not feel that this medication was the appropriate medication for this resident's behavioural needs and that it was not always effective. The effectiveness of this medication is not always documented by the registered staff according to the PRN record and the nursing notes reviewed by this Inspector. The registered staff administered the medication three times over the course of two weeks, it was documented only once as being effective.

On June 5, 2014, Inspector reviewed the home's policy titled "Responsive Behaviour Program" which indicates that if the interventions have not been effective to prevent or reduce responsive behaviours or support the resident, initiate alternative approaches and update the care plan as necessary. The policy also indicates the following; engage the resident in activities that are meaningful, monitor the effectiveness of medications, conduct behavioural mapping and document resident's response to the interventions and complete reassessments when interventions are not effective. The policy titled "Responsive Behaviour Program" has not been implemented with respect to resident # 4.

The licensee did not ensure that resident # 4 was protected from neglect by the licensee or staff. [s. 3. (1) 3.]

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. 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. On June 4, 2014 , Inspector 580 conducted an audit of the medication storage room and noted two expired prescribed medications for a resident. The expired medications were; IM Ketorolac, 30 mg/1 ml prn up to 4 times per month, expired January 2014 and Nylan-beclo spray, 50 mcg,1 spray both nostrils, expired May 2014. On June 5, 2014, Inspector 580 reviewed the Home's Standards of Medication Administration policy revised February 2008 which indicated that expired medication shall be removed and returned to the pharmacy. The Home's Standards of Medication

Administration policy was not complied with.

On June 4, 2014, at approximately 0940, Inspector 580 observed registered staff # 101 and registered staff # 112 preparing to administer medication to resident # 29. Inspector 580 observed the two registered staff sign for the medication in the medication room and then proceed to the resident home area and administer the medication. When asked by Inspector 580 regarding the process of signing before administering medication, the two registered staff stated that it was the home's process.

On June 4, 2014 at 0940 am Inspector 580 observed registered staff # 101 and registered staff # 110 sign for and then administer a medication to resident # 32. When asked by Inspector 580 regarding the process of signing before administering medication, both registered staff stated that it was the home's process. On June 5, 2014, Inspector 580 reviewed the Home's Drug Administration Policy, revised September 24, 2001 and the Nursing's Responsibilities: Drug Administration Policy, revised February 2008, which stated that the RN pouring the medication must administer it, then document it.

Inspector 580 reviewed the Home's Documentation of Analgesia for Pain Control policy revised February 2008 which stated that the effectiveness of the pain medication is to be documented after the administration of the medication.

On June 4, 2014, Inspector 580 observed registered staff # 101, accompanied by registered staff # 110 document a progress note related to pain control for resident # 32. Inspector 580 reviewed resident #32's progress notes to determine if the effectiveness of the pain medication was documented on June 1 and May 28, 2014. Inspector noted that there was no documentation regarding the effectiveness of the pain medication for this resident on June 1 or May 28, 2014. The Home's Documentation of Analgesia for Pain Control policy was not complied with.

On June 4, 2014, registered staff # 111 informed Inspector 580 that they do not complete drug destruction with the pharmacist. On June 4, 2014, registered staff # 113 also confirmed that they do not complete drug destruction with the pharmacist. On June 4, 2014, the ADOC informed Inspector 580 that the registered nurses complete the drug destruction with the pharmacist. On June 5, 2014, Inspector 580 reviewed the Home's Drug Destruction Policy, Revised February 2009, which identified the following: that all surplus drugs will be destroyed by the Director of Resident Care or

designate and the Pharmacist at least every 3 months after the Pharmacy and Therapeutics Meeting.

On June 4, 2014, registered staff # 113 and # 110 indicated to Inspector 580 the following: that on separate occasions, medications that are poured but held, medications that are accidentally dropped, or some medications that are discontinued are dropped into a container filled with water kept on the medication cart and that there is no accountability or documentation system in place to support this. Inspector reviewed the Drug Destruction Policy, revised February 2008 which identified that the Registered Nurse/Registered Practical Nurse removes discontinued/deceased resident's drugs from the storage area and completes the Surplus Prescribed Drug Record.

On June 4, 2014, the ADOC and registered staff # 113 told Inspector 580 that the Home does not keep drug destruction records and that the pharmacy removed the records when the current page is completed. On June 5, 2014, Inspector 580 reviewed the Home's Drug Destruction policy revised February 2008 which states that the Director of Care (DOC) will make a copy of the Surplus Prescribed Drug Record sheets and keep it in the Home for 2 years. On June 5, 2014, Inspector 580 reviewed the Home's Standards of Medication Administration Policy, revised February 2008, which indicates that discontinued, unused, expired, recalled, deteriorated, unlabelled medications shall be removed and returned to the pharmacy for correction or to be destroyed. The Home's Drug Destruction and Standards of Medication Administration policies were not complied with.

On June 5, 2014, Inspector 580 reviewed the Home's contract with the contracted pharmacy which included the following - The pharmacy is expected to be an active participant of the Pharmacy and Therapeutic Committee at a minimum of four times a year – Inspector 580 reviewed the minutes of meetings of May 14, 2014, February 12, 2013, June 19, 2012. On June 5, 2014, Inspector 580 reviewed the Home's Pharmacy Services Contract Information policy revised February 2008 which states that there will be a minimum of four Pharmacy and Therapeutic Committee meetings per year. Based on the Pharmacy and Therapeutic minutes, meetings were held only once per year. The Home's Pharmacy Services Contract Information policy was not complied with.

The licensee did not ensure, that the home's policies related to medication management were complied with. [s. 8. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

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

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

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).

Findings/Faits saillants :

1. On June 4, 2014 Inspector reviewed resident # 6's health care record. It was noted on the Medication Administration Record (MAR) over a period of 2 months that the information with regards to resident # 6's restraint use is recorded, however there are only 4 days where a registered staff has signed that the resident's condition had been reassessed. Inspector interviewed registered staff # 113 and was informed that this reassessment has not been done consistently by the registered staff. Registered staff

112 also acknowledged that the registered staff have failed to reassess the residents condition related to the use of the restraint every 8 hours.

The licensee failed to ensure that the resident's condition has been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances. [s. 110. (2) 6.]

2. On May 29th, 2014 Inspector 542 reviewed resident # 6's health care record specifically related to the use of restraints. A review of the resident's "physical restraint monitoring record" for a one month period, identified that there was no documentation over a 15 day period, for a 3 hour block each day while this resident was restrained. Inspector interviewed PSW staff # 118 and PSW staff # 109 and was informed that when the PSW that is assigned to resident # 6 leaves at 1100 AM, no other PSW assumes this assignment. ADOC informed Inspector that their assignment sheets indicate that after the 7-11 AM shift leaves, the remaining PSW takes over the assignment until 3 PM, however this is not occurring. Inspector reviewed two additional physical restraint monitoring records for two separate residents (resident # 7 and # 15), both records had missing documentation over the same 15 day period for 3 hours each day while residents were restrained.

On May 29th, 2014 Inspector reviewed resident # 4's Physical Restraint Monitoring Record over a one month period. Inspector noted several missing signatures on the record. The record revealed many missing signatures at times for 12 hour intervals. Inspector reviewed licensee's policy titled "Minimizing of Restraining of Residents and Use of Personal Assistance Service Devices (PASD)" which indicates that hourly observation and every two hour release of restraint is to be documented.

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

Additional Required Actions:

CO # - 003, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. On May 29, 2014 Inspector reviewed resident #4's current care plan with regards to dental care. The care plan identified that the resident has some or all natural teeth lost, daily cleaning of dentures or daily mouth care, does not allow upper dentures to be put in. During an interview with PSW staff # 104, Inspector was informed that resident # 4 has dentures but will refuse them, has no natural teeth and that a toothette is used to provide oral care. Inspector also interviewed PSW staff # 120 and was informed that the resident has no teeth or dentures and that the staff use the toothette. The plan of care for resident # 4 does not mention the use of the toothettes and has conflicting information as to whether the resident has some natural teeth or dentures.

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. On June 4, 2014, Inspector 580 reviewed resident #1's care plan which indicated that staff were to remove the transfer sling when the resident is up in the wheelchair, or at least pull the sling up so the resident is not sitting on the sling. Inspector 580 interviewed PSW #109 and PSW #118, both of whom stated that they leave the sling under the resident's buttocks but straighten it out and both were not aware of the care plan instructions. On June 4, 2014 at lunch and supper meal services, Inspector 580 observed resident #1 with the sling positioned under their buttocks which contradicts the care plan.

The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

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 resident # 4's plan of care sets out clear directions to staff and others who provide direct care to the resident; that resident # 1's care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspectors 542 and 580 reviewed the health care record of 5 residents (resident #1, #2, #3, #5 and # 8) and were unable to locate any evidence that an annual dental assessment and other preventative dental services were offered. On June 2, 2014 Inspector 542 interviewed the ADOC and was informed that annual dental assessments and other preventative dental services are not offered annually to the residents. ADOC stated that she was unaware that this was a requirement. On June 3, 2014, Inspector 580 interviewed registered practical nurse # 112 who also confirmed that annual dental assessments are not offered to the residents. Inspector 580 reviewed the home's policy on Oral Hygiene which indicated that the home is to offer annual dental assessments.

The licensee failed to ensure that residents are offered an annual dental assessment and other preventative dental services, subject to payment being authorized by the resident/SDM if payment is required. [s. 34. (1) (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 all residents are offered an annual dental assessment and other preventative dental services, subject to payment being authorized by the resident/SDM if payment is required, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Over the course of the inspection, Inspectors observed resident # 4 sitting in their wheelchair for most of the day and early evening. Resident # 4 was not observed to be involved in any type of activity throughout the duration of the inspection. Resident # 4 presented with a responsive behaviours. Occasionally the staff would offer resident # 4 something to drink or move their wheel chair to a different location. Resident is dependent on staff for activities of daily living, for example eating, dressing etc. On June 5, 2014 Inspector reviewed resident # 4's health care record and was unable to locate any type of behavioural assessment or reassessment other than a report from 2010 indicating that the resident was assessed by a geriatric physician and several recommendations were made. Inspector was informed by registered staff # 113 that none of the recommendations were trialled. Inspector interviewed registered staff member # 112 and was informed that resident # 4 had not been reassessed for approximately 2-3 years with regards to their responsive behaviours. In 2011, resident was started on a new medication at 2000, this medication was discontinued in November 2012. Currently, when resident # 4 displays responsive behaviours, the registered staff provide a different medication four times/day when required. Registered staff # 113 told the Inspector that they did not feel that this medication was the appropriate medication for this resident's behavioural needs and that it was not always effective. The effectiveness of this medication is not always documented by the registered staff according to the PRN record and the nursing notes reviewed by this Inspector. The registered staff administered the medication three times over the course of two weeks, it was documented only once as being effective. On June 5, 2014, Inspector reviewed the home's policy titled "Responsive Behaviour Program" which indicates that if the interventions have not been effective to prevent or reduce responsive behaviours or support the resident, initiate alternative approaches and update the care plan as necessary. The policy also indicates the following; engage the resident in activities that are meaningful, monitor the effectiveness of medications, conduct behavioural mapping and document resident's response to the interventions and reassessments when interventions are not effective. The policy titled "Responsive Behaviour Program" has not been implemented with respect to resident # 4.

The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. [s. 53. (4) (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 for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the residents, including assessments, reassessments, and interventions and that the resident's responses to interventions are documented specifically related to resident # 4, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. On May 26th, 2014 Inspector interviewed ADOC and was informed that the licensee does not currently convene semi-annually meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council. The ADOC stated that they are planning to do this but they are currently developing the policies and procedures and they hope that a formal process will be developed by the fall.

The licensee has failed to ensure that semi-annual meetings are convened to advise residents' families and persons of importance to residents of their right to establish a Family Council. [s. 59. (7) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that semi-annual meetings are convened to advise residents' families and persons of importance to residents of their rights to establish a Family Council, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. On June 2, 2014 Inspector 542 reviewed resident # 4's health care record pertaining to nutrition and hydration. Inspector noted that over a 7 month period there was no documentation indicating that resident # 4 was receiving any food intake. Inspector reviewed the seating plan for the dining room meal service and noted resident # 4 was not assigned a seat at a table. The Personal Support Workers (PSWs) complete a form called the "Daily Intake Tracker" after all meals for each resident, however resident # 4 was not listed as one of the resident's they monitor for daily nutritional intake. The Registered staff keep a record of the amount of the nutritional supplement resident # 4 is consuming on another document titled, "Nutritional Intake Record." This document also identified that resident # 4's meal location is not in the dining room. Inspector interviewed several PSW staff members and was informed that resident # 4, at times, will consume, yogurt, mashed potatoes, and bananas. Inspector interviewed the Registered Dietitian (RD) and was informed that the resident does not consume anything solid and that they typically only consume fluids. The documentation only supports that resident # 4 is consuming some of the ordered nutritional supplements and no other fluids. The RD stated that the resident has been like this for quite some time and does not believe any interventions have been tried in an attempt to have the resident consume solid foods. On June 4, 2014 Inspector observed resident # 4 for 45 minutes after the lunch service. Inspector interviewed two PSWs at separate times and asked them if this resident was offered lunch, both PSWs stated that the resident was not offered lunch as they typically do not eat. On June 4th, 2014 Inspector had a brief conversation with the ADOC and Inspector expressed concerns with regards to resident # 4. ADOC informed Inspector that the RD was going to put something in place today to ensure that resident was being offered the three meals daily. On June 4th, Inspector reviewed the note from the RD, which stated that staff are to offer the meal choice prior to providing resident with a supplement and if resident refuses to eat, document it, then document how many/much of the supplement the resident consumed, track fluids consumed (regular fluids) under the fluids portion of the chart.

The licensee failed to ensure that resident # 4 is offered a minimum of three meals daily. [s. 71. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident # 4 is being offered a minimum of three meals daily, to be implemented voluntarily.

WN #9: 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. (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).

Findings/Faits saillants :

1. On May 27, 2014, Inspector 580 reviewed the Residents' Council monthly meeting minutes for 2013 and 2014 and did not find any documentation indicating that the results of the satisfaction survey had been made available to the Residents' Council to seek their advice. On May 29, 2014, resident #25, President of the Residents' Council told Inspector 580 that they do not remember being asked about a survey that would be sent out to residents and their families. On June 3, 2014, Recreational/Volunteer Coordinator #111, told Inspector 580 that they were not aware if the Residents' Council had received the results of the satisfaction survey. On June 3, 2014, resident #5, the former Residents' Council President told Inspector 580 that they do not remember being told about any survey planning and do not remember being asked to review any survey during the term as president. On June 3, 2014, the ADOC stated that she was not aware if the Residents' Council had been asked to review and approve the survey.

The licensee failed to ensure that the results of the survey are documented and made available to the Residents' Council to seek their advice. [s. 85. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the results of the satisfaction survey are documented and made available to the Residents' Council to seek their advice, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. On June 4, 2014 registered staff # 112 was interviewed by this Inspector and was asked if an analysis of the restraining of residents by use of a physical device was completed monthly. The registered staff # 112 informed inspector that they do not perform a monthly analysis and that they review the restraints quarterly. Registered staff # 113 also confirmed that the home does not currently complete a monthly analysis of restraining of residents by use of a physical device.

The licensee failed to ensure that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis. [s. 113. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a monthly analysis of the restraining of residents by use of a physical device under section 31 of the Act is undertaken, to be implemented voluntarily.

WN #11: 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. On June 4, 2014, at 0940, Inspector 580 observed registered staff # 101 and # 113 prepare to administer a medication to resident # 1. Inspector 580 observed registered staff # 101 review the physician's medication order, the medication administration record (MAR) and the medication label. The Inspector observed that the physician's medication order for medication stated it was to be administered at 2000 hours whereas the MAR indicated it was to be administered at 0900 hours. The Inspector questioned why the order did not match the MAR. The registered staff # 113 remembered that they had forgotten to get a physician's order for the change in time for the medication as suggested by the Registered Dietitian during a conversation several weeks ago. According to the MAR, resident # 1 has been administered the medication daily at 0900 AM instead of 2000 PM as ordered by the physician.

The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, specifically related to resident # 1, to be implemented voluntarily.

WN #12: 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. (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).

Findings/Faits saillants :

1. On June 2, 2014 Inspector reviewed the health care record for resident # 31. Inspector was unable to locate any information as to whether resident was screened for tuberculosis or any indication that resident # 31 was screened 90 days prior to admission. Inspector interviewed ADOC and was informed that the TB screening is conducted on admission however ADOC was unable to locate whether resident received this screening while residing in the home or 90 days prior to admission.

The licensee failed to ensure that each resident admitted to the home is 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. [s. 229. (10) 1.]

2. On June 2, 2014 Inspector reviewed the health care records for residents # 26, # 30 and # 31. All residents did not have documentation to support that they were offered immunizations against, tetanus and diphtheria vaccine. Resident # 26's health care record indicated a doctor's order and a consent for the pneumococcal, tetanus and diphtheria vaccine however no indication that the resident was offered the vaccines. Inspector interviewed ADOC and was informed that the home does offer the tetanus and diphtheria vaccine on admission however the ADOC was unable to locate any of the documentation to support this.

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

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are 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; that residents are offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On June 4, 2014 Inspector reviewed resident # 22's health care record (who was admitted 2012) and was unable to locate any record of resident's care conference that was to be provided six weeks after admission and annually thereafter. Registered staff # 112 informed Inspector that they were also unable to locate any record indicating that a care conference was held with the resident and that they believe it was missed. ADOC stated that the care conference record should be located on the resident's chart.

The licensee has failed to ensure that a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker. [s. 27. (1)]

WN #14: 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. (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).

Findings/Faits saillants :

1. On June 5, 2014, Inspector 580 requested the Home's written staffing plan from the Director of Care (DOC). The DOC provided the Home's policy on Administrator-On-Call – which had been last reviewed by the Home on June 8, 2012. The DOC and ADOC also provided the Home's Staffing Requirements Worksheet for 2014-2015. Inspector reviewed both documents and noted that the two documents did not contain a back-up plan for nursing and personal care staffing or evidence of evaluation at least annually in accordance with best-practices. The DOC and ADOC then provided the Inspector with another Home's (one of the MIC groups) staffing plan and informed the Inspector that the Homes shared their policies and documents. Inspector reviewed the document and noted that it did not match this Home's April 28, 2014 to June 8, 2014 schedule for nursing and personal care staff.

The licensee failed to ensure that the staffing plan included 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 that it is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [s. 31. (3)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On June 2, 2014 Inspector 542 reviewed resident # 4's health care record and was unable to locate any alternatives to restraining that were considered, and tried, but have not been effective in addressing the risk. Inspector interviewed Restorative care staff # 121 and was informed that they were unaware if any alternatives to restraining have been tried for resident # 4 as resident has always had 2 different restraints. ADOC stated that resident # 4 has had both of the restraints for the past year and was unaware if any alternatives have ever been tried.

The licensee has failed to ensure that alternatives to restraining the resident have been considered, and tried. [s. 31. (2) 2.]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the

Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. On May 28th, 2014, the ADOC provided the Inspector with a copy of the admission package that is provided to the resident and Substitute Decision Makers (SDM) on admission. The ADOC informed the Inspector that the contents were outdated and that they are currently working on revising the contents. Inspector reviewed the package and noted that it did not contain the following;
- the current Residents' Bill of Rights
- the home's mission statement
- the home's policy to promote zero tolerance of abuse and neglect of residents.
- an explanation of the duty to make mandatory reports related to incidents resulting in harm or risk of harm to a resident, such as, improper or incompetent treatment or care of a resident, abuse by anyone or neglect by the licensee or staff, unlawful conduct, misuse or misappropriation of a resident's money or of funding provided to the licensee
- the home's procedure for initiating complaints to the licensee
- the home's policy on minimizing the restraining of residents and how to obtain a copy of the policy
- the name and telephone number of the licensee
- information about the Residents' Council

The licensee failed to ensure that the admission package provided to every resident and to the Substitute Decision-Maker of the resident is current and includes everything required by this Act and Regulations. [s. 78. (2) (a)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On May 26th, 2014 during the initial tour the Inspector could not locate the home's policy to promote zero tolerance of abuse and neglect of residents and the home's procedure for initiating complaints to the licensee. Inspector interviewed ADOC and was informed that these documents were previously posted on the communication board however someone must have removed them.

The licensee failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents and the home's procedure for initiating complaints to the licensee is posted in the home, in a conspicuous and easily accessible location in manner that complies with the requirements, if any, established by the regulations. [s. 79. (1)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 119. Retaining of pharmacy service provider

Specifically failed to comply with the following:

s. 119. (3) There must be a written contract between the licensee and the pharmacy service provider setting out the responsibilities of the pharmacy service provider. O. Reg. 79/10, s. 119 (3).

Findings/Faits saillants :

1. On June 4, 2014, the ADOC, informed Inspector 580 that the Home has a pharmacy provider contract in place. On June 4, 2014, the ADOC provided Inspector 580 with a copy of the pharmacy service provider contract with which had expired. On June 4, 2014, the ADOC provided Inspector 580 with a copy of a letter dated May 1, 2012 to amend the pharmacy contract of June 1, 2010 to May 31, 2012 between the servicing pharmacy and the Home. This contract was not provided to the Inspector. Inspector 580 reviewed a letter of extension dated May 1, 2012 signed by the Home stating that this would be the last extension and that a new Request for Proposals (RFP) would be put out for pharmacy services beyond May 31st, 2014. On June 9, 2014 Inspector 580 reviewed the Home's Pharmacy Services Contract Information Policy, which was revised February 2008, and states that there will be a letter of understanding indicating the agreement between the Pharmacy providing the service and the Home and that this will be signed annually and kept on file.

The licensee failed to ensure that there was a written contract between the licensee and the pharmacy service provider setting out the responsibilities of the pharmacy service provider. [s. 119. (3)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
8. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. On May 28th, 2014, Inspector was provided with a copy of the admission package that is provided to the resident and Substitute Decision Makers (SDM) on admission. The Assistant Director of Care (ADOC) informed inspector that the contents were outdated and that they are currently working on revising the contents. Inspector reviewed the package and noted that it did not include the Ministry's toll-free telephone number for making complaints about the home and its hours of service.

The licensee failed to ensure that the admission package included the Ministry's toll-free telephone number for making complaints about the home and its hours of service. [s. 224. (1) 8.]

Issued on this 4th day of July, 2014

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER LAURICELLA (542), VALA MONESTIMEBELTER (580)
Inspection No. / No de l'inspection :	2014_281542_0014
Log No. / Registre no:	S-000221-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 3, 2014
Licensee / Titulaire de permis :	THE LADY MINTO HOSPITAL AT COCHRANE 241 EIGHTH STREET, P.O. BOX 4000, COCHRANE, ON, P0L-1C0
LTC Home / Foyer de SLD :	VILLA MINTO 241 EIGHTH STREET, P.O. BOX 280, COCHRANE, ON, P0L-1C0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Fern Morrissette

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

To THE LADY MINTO HOSPITAL AT COCHRANE, 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. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

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.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that resident # 4:
1. Is given reasonable assistance to pursue their social, cultural, religious, spiritual and other interests and develop their potential.
2. Is offered a minimum of 3 meals daily and receives assessments, reassessments and interventions with regards to nutrition and hydration.
3. Receives assessments, reassessments and interventions with regards to responsive behaviours.

This plan shall be submitted in writing to Jennifer Lauricella, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564-3133. This plan must be submitted by July 11, 2014 and fully implemented by July 18th, 2014.

Grounds / Motifs :

1. The licensee did not ensure that every resident is protected from neglect. Over the course of the inspection, Inspectors observed resident # 4 sitting in their wheelchair for most of the day and early evening. Resident # 4 was not observed to be involved in any type of activity throughout the duration of the inspection. Resident # 4 also presented with responsive behaviours. Occasionally the staff were observed offering resident # 4 something to drink or moving their wheel chair to a different location. Inspectors did not observe the resident to be partaking in any of the meals in the dining room. Resident # 4 is

dependent on staff for activities of daily living, for example eating, dressing etc.

On May 29th, 2014 Inspector 542 reviewed resident # 4's health care record. It was noted on the Activity Participation Record and in the notes section of Mede-care that the resident had only been brought to or provided with one activity over a 5 month period. Inspector was informed by the Recreation/Volunteer Coordinator that the Activity Participation Record along with the notes in Mede-care is where the attendance or refusal for each resident is documented. The Recreation/Volunteer Coordinator also informed the Inspector that resident # 4 likes to attend church, music activities and conversing/reminiscing.
On June 2, 2014 Inspector 542 reviewed resident # 4's health care record pertaining to nutrition and hydration. Inspector noted that over a 7 month period there was no documentation indicating that resident # 4 was receiving any food intake. Inspector also reviewed the seating plan for the dining room meal service and noted resident # 4 was not assigned a seat at a table. The Personal Support Workers (PSWs) complete a form called the "Daily Intake Tracker" after all meals for each resident, however resident # 4 was not listed as one of the residents they monitor for daily nutritional intake. The Registered staff keep a record of the amount of the nutritional supplement resident # 4 is consuming on another document titled, "Nutritional Intake Record." This document also identified that resident # 4's meal location is in front of the nursing station or activity room. Inspector interviewed several PSW staff members and was informed that resident # 4 at times will consume, yogurt, mashed potatoes, and bananas. Inspector interviewed the Registered Dietitian (RD) and was informed that the resident does not consume anything solid and that they typically only consume fluids. The documentation only supports that resident # 4 is consuming some of the ordered nutritional supplements and no other fluids. The RD stated that the resident has been like this for quite some time and does not believe any interventions have been tried in an attempt to have the resident consume solid foods. On June 4, 2014 Inspector observed resident # 4 for 45 minutes after the lunch service. Inspector interviewed two PSWs at separate times and asked them if this resident was offered lunch, both PSWs stated that the resident was not offered lunch as they typically do not eat. On June 4th, 2014 Inspector had a brief conversation with the ADOC and Inspector expressed concerns with regards to resident # 4. ADOC informed Inspector that the RD was going to put something in place today to ensure that resident is being offered 3 meals daily. On June 4th, Inspector reviewed the note from the RD, which stated that staff are to offer the meal choice prior to providing resident with a supplement and if resident refuses to eat, document it, then document how

many/much of the supplement the resident consumed, track fluids consumed (regular fluids) under the fluids portion of the chart.

On June 5th, 2014 Inspector reviewed resident # 4's health care record and was unable to locate any type of behavioural assessment or reassessment other than a report from 2010 indicating that the resident was assessed by a geriatric physician and several recommendations were made. Inspector was informed by registered staff # 113 that none of the recommendations were trialled. Inspector interviewed registered staff member # 112 and was informed that resident # 4 has not been reassessed for approximately 2-3 years with regards to their responsive behaviours. In 2011, resident was started on a new medication at 2000, this medication was discontinued in November 2012. Currently, when resident # 4 displays responsive behaviours, the registered staff provide a different medication four times/day when required. Registered staff # 113 told the Inspector that they did not feel that this medication was the appropriate medication for this resident's behavioural needs and that it was not always effective. The effectiveness of this medication is not always documented by the registered staff according to the PRN record and the nursing notes reviewed by this Inspector. The registered staff administered the medication three times over the course of two weeks, it was documented only once as being effective. On June 5, 2014, Inspector reviewed the home's policy titled "Responsive Behaviour Program" which indicates that if the interventions have not been effective to prevent or reduce responsive behaviours or support the resident, initiate alternative approaches and update the care plan as necessary. The policy also indicates the following; engage the resident in activities that are meaningful, monitor the effectiveness of medications, conduct behavioural mapping and document resident's response to the interventions and complete reassessments when interventions are not effective. The policy titled "Responsive Behaviour Program" has not been implemented with respect to resident # 4.

The licensee did not ensure that resident # 4 was protected from neglect by the licensee or staff. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 18, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that the home's policies related to the medication management system are complied with.

Grounds / Motifs :

1. On June 4, 2014 , Inspector 580 conducted an audit of the medication storage room and noted two expired prescribed medications for a resident. The expired medications were; IM Ketorolac, 30 mg/1 ml prn up to 4 times per month, expired January 2014 and Nylan-beclo spray, 50 mcg,1 spray both nostrils, expired May 2014. On June 5, 2014, Inspector 580 reviewed the Home's Standards of Medication Administration policy revised February 2008 which indicated that expired medication shall be removed and returned to the pharmacy. The Home's Standards of Medication Administration policy was not complied with.

On June 4, 2014, at approximately 0940, Inspector 580 observed registered staff # 101 and registered staff # 112 preparing to administer medication to resident # 29. Inspector 580 observed the two registered staff sign for the medication in the medication room and then proceed to the resident home area and administer the medication. When asked by Inspector 580 regarding the process of signing before administering medication, the two registered staff stated that it was the home's process.

On June 4, 2014 at 0940 am Inspector 580 observed registered staff # 101 and

registered staff # 110 sign for and then administer a medication to resident # 32. When asked by Inspector 580 regarding the process of signing before administering medication, both registered staff stated that it was the home's process. On June 5, 2014, Inspector 580 reviewed the Home's Drug Administration Policy, revised September 24, 2001 and the Nursing's Responsibilities: Drug Administration Policy, revised February 2008, which stated that the RN pouring the medication must administer it, then document it.

Inspector 580 reviewed the Home's Documentation of Analgesia for Pain Control policy revised February 2008 which stated that the effectiveness of the pain medication is to be documented after the administration of the medication.

On June 4, 2014, Inspector 580 observed registered staff # 101, accompanied by registered staff # 110 document a progress note related to pain control for resident # 32. Inspector 580 reviewed resident #32's progress notes to determine if the effectiveness of the pain medication was documented on June 1 and May 28, 2014. Inspector noted that there was no documentation regarding the effectiveness of the pain medication for this resident on June 1 or May 28, 2014. The Home's Documentation of Analgesia for Pain Control policy was not complied with.

On June 4, 2014, registered staff # 111 informed Inspector 580 that they do not complete drug destruction with the pharmacist. On June 4, 2014, registered staff # 113 also confirmed that they do not complete drug destruction with the pharmacist. On June 4, 2014, the ADOC informed Inspector 580 that the registered nurses complete the drug destruction with the pharmacist. On June 5, 2014, Inspector 580 reviewed the Home's Drug Destruction Policy, Revised February 2009, which identified the following: that all surplus drugs will be destroyed by the Director of Resident Care or designate and the Pharmacist at least every 3 months after the Pharmacy and Therapeutics Meeting.

On June 4, 2014, registered staff # 113 and # 110 indicated to Inspector 580 the following: that on separate occasions, medications that are poured but held, medications that are accidentally dropped, or some medications that are discontinued are dropped into a container filled with water kept on the medication cart and that there is no accountability or documentation system in place to support this. Inspector reviewed the Drug Destruction Policy, revised February 2008 which identified that the Registered Nurse/Registered Practical Nurse removes discontinued/deceased resident's drugs from the storage area

and completes the Surplus Prescribed Drug Record.

On June 4, 2014, the ADOC and registered staff # 113 told Inspector 580 that the Home does not keep drug destruction records and that the pharmacy removed the records when the current page is completed. On June 5, 2014, Inspector 580 reviewed the Home's Drug Destruction policy revised February 2008 which states that the Director of Care (DOC) will make a copy of the Surplus Prescribed Drug Record sheets and keep it in the Home for 2 years. On June 5, 2014, Inspector 580 reviewed the Home's Standards of Medication Administration Policy, revised February 2008, which indicates that discontinued, unused, expired, recalled, deteriorated, unlabelled medications shall be removed and returned to the pharmacy for correction or to be destroyed. The Home's Drug Destruction and Standards of Medication Administration policies were not complied with.

On June 5, 2014, Inspector 580 reviewed the Home's contract with the contracted pharmacy which included the following - The pharmacy is expected to be an active participant of the Pharmacy and Therapeutic Committee at a minimum of four times a year – Inspector 580 reviewed the minutes of meetings of May 14, 2014, February 12, 2013, June 19, 2012. On June 5, 2014, Inspector 580 reviewed the Home's Pharmacy Services Contract Information policy revised February 2008 which states that there will be a minimum of four Pharmacy and Therapeutic Committee meetings per year. Based on the Pharmacy and Therapeutic minutes, meetings were held only once per year. The Home's Pharmacy Services Contract Information policy was not complied with.

The licensee did not ensure, that the home's policies related to medication management were complied with. (580)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 18, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that resident # 6, # 7 and # 15 are assessed, reassessed, monitored and that the resident's response is documented with regards to restraint use. This plan shall be submitted in writing to Jennifer Lauricella, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564-3133. This plan must be submitted by July 11th, 2014 and fully implemented by July 18th, 2014.

Grounds / Motifs :

1. A previous compliance order was issued April 2013 related to O.Reg 79/10 s. 110. (7) during inspection # 2013_138151_0009, this order was complied August 22, 2013 during inspection # 2013_140158_0020.

2. On May 29th, 2014 Inspector 542 reviewed resident # 6's health care record specifically related to the use of restraints. A review of the resident's "physical restraint monitoring record" for a one month period, identified that there was no documentation over a 15 day period, for a 3 hour block each day while this resident was restrained. Inspector interviewed PSW staff # 118 and PSW staff # 109 and was informed that when the PSW that is assigned to resident # 6 leaves at 1100 AM, no other PSW assumes this assignment. ADOC informed Inspector that their assignment sheets indicate that after the 7-11 AM shift leaves, the remaining PSW takes over the assignment until 3 PM, however this is not occurring. Inspector reviewed two additional physical restraint monitoring records for two separate residents (resident # 7 and # 15), both records had missing documentation over the same 15 day period for 3 hours each day while residents were restrained.

On May 29th, 2014 Inspector reviewed resident # 4's Physical Restraint Monitoring Record over a one month period. Inspector noted several missing signatures on the record. The record revealed many missing signatures at times for 12 hour intervals. Inspector reviewed licensee's policy titled "Minimizing of Restraining of Residents and Use of Personal Assistance Service Devices (PASD)" which indicates that hourly observation and every two hour release of restraint is to be documented.

The licensee has failed to ensure that the documentation that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 6. All assessment, reassessment and monitoring, including the resident's response. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 18, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that resident #6's condition is reassessed and the effectiveness of the restraining is evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances. This plan shall be submitted in writing to Jennifer Lauricella, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564-3133. This plan must be submitted by July 11th, 2014 and fully implemented by July 18th, 2014.

Grounds / Motifs :

1. On June 4, 2014 Inspector reviewed resident # 6's health care record. It was noted on the Medication Administration Record (MAR) over a period of 2 months that the information with regards to resident # 6's restraint use is recorded, however there are only 4 days where a registered staff has signed that the resident's condition had been reassessed. Inspector interviewed registered staff # 113 and was informed that this reassessment has not been done consistently by the registered staff. Registered staff # 112 also acknowledged that the registered staff have failed to reassess the resident's condition related to the use of the restraint every 8 hours.

The licensee failed to ensure that the resident's condition has been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 18, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board 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.

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

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 3rd day of July, 2014

Signature of Inspector /
Signature de l'inspecteur :

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

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