Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 16, 2017	2017_587129_0012	023882-17	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF TANSLEY WOODS
4100 Upper Middle Road BURLINGTON ON L7M 4W8

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

PHYLLIS HILTZ-BONTJE (129), CAROL POLCZ (156), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 17, 18, 19, 20, 23, 24, 2017.

The following additional inspections were completed concurrently with this Resident Quality Inspection: : Critical Incident System (CIS) inspection Log #025342-16 related to missing resident , CIS inspection Log #019073-17 related to the management of responsive behaviours, CIS inquiry Log #020400-17 related to abuse and Follow-up inspection Log #012684-17 related to the management of responsive behaviours.
At the time of this inspection it was identified that the licensee had achieved compliance with the previously issued compliance order related to O. Reg. 79/10, s. 54.

During the course of the inspection, the inspector(s) spoke with residents, resident's family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), 3 Resident Assessment Instrument (RAI) Coordinators, Recreation staff, Director of Nursing (DOC), Assistant Director of Nursing (ADOC) and the Assistant General Manager (AGM).
During the course of this inspection, the inspectors toured the home, reviewed resident clinical records and reviewed the licensee's policy and procedure documents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **7 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 54.	CO #001	2017_570528_0018	156

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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to Protect.
Specifically failed to comply with the following:
Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

In accordance with the Long-Term Care Homes Act, 2007, Ontario Regulation 79/10, s. 2 (1) physical abuse is defined as: the use of physical force by a resident that causes physical injury to another resident.

The licensee failed to ensure that resident #024 was protected from physical abuse when on an identified date in 2017, resident #020 was in an physical altercation with resident #024 and as a result resident #024 sustained an injury. As per interview with the Acting Director of Care (ADOC) on October 23, 2017, staff were aware that resident #020 demonstrated territorial behaviour, posed a risk and had previously pushed a co-resident; however, the home did not implement any interventions to prevent a re-occurrence until after this incident.
The licensee failed to ensure that the resident was protected from physical abuse when resident #024 was injured as a result of an altercation with resident #020. [s. 19. (1)]

Additional Required Actions:

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

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #004 and resident #006's plans of care provided clear directions to staff and others who provided direct care to the resident.

i) Resident #004 fell on an identified date in 2017, resulting in an injury. Registered Nurse (RN) #106 confirmed that the resident's wheelchair was to be positioned in accordance with what they identified as the requirement for this resident. At the time of this fall it was confirmed that the resident's wheelchair had not been positioned in accordance with the identified requirements. The Kinesiologist, RN #106 and the resident's clinical record confirmed that the resident's plan of care related to prevention of falls, included care intervention related to the positioning of the wheelchair in order to ensure proper positioning and comfort. The Kinesiologist confirmed resident #004 would not have been able to purposefully get out of the wheelchair. The Kinesiologist and RN #106 confirmed that the written plan of care had not included the specific directions for the positioning of the wheelchair whenever the resident was in the chair, as identified by RN #106.
The licensee failed to ensure resident #004's written plan of care provided clear directions to staff and others providing care to the resident when the care direction had not specified the requirement to position the wheelchair as identified by RN #106 at the

time of this inspection.

ii) Resident #006 was noted to be incontinent on the last Minimum Data Set (MDS) assessment completed on an identified date in 2017. The plan of care indicated that the staff were to use the appropriate fitting incontinent product as per a supplier's form found in the resident's bathroom cabinet. At the time of this inspection Personal Support Worker (PSW) #120 and #104 reported that the resident wore a specified incontinence product; however, the sign in the resident's bathroom cabinet indicated a different product was used for days, evenings and nights. The plan of care did not set out clear directions to staff and others providing care to the resident in regards to the resident's continence product. 156 [s. 6. (1) (c)]

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

Registered Practical Nurse (RPN) #114 confirmed that resident #006 fell frequently and explained that one of the factors related to falls was an identified change in the resident's status. RPN #114 confirmed that as a result of this situation resident #006's plan of care contained directions to monitor the resident's status once on the day, evening and night shifts. RPN #114 confirmed that registered staff were to document that they had completed this monitoring activity on the Medication Administration Record (MAR). RPN #114 and the October 2017 MAR confirmed the care specified in the resident's plan of care had not been provided when the MAR indicated that the resident's status had not been monitored for 13 shifts during the first 19 days of October 2017.
Care was not provided to resident #006 as specified in the plan of care when staff did not monitor the resident's status as directed in the plan of care. [s. 6. (7)]

3. The licensee failed to ensure that the resident's plan of care was reviewed and revised when the resident's care needs changed.

i) Resident #004's care needs changed when they fell on an identified date in 2017, resulting in an injury. RN #106 confirmed that the resident fell as a result of not being positioned in accordance with the requirements for this resident. RN #106 and the Kinesiologist confirmed that there were no changes made to the resident's plan of care in order to prevent a recurrence of the fall the resident had experienced. (129)

ii) Resident #005's care need changed when it was identified during Minimum Data Set (MDS) coding completed on an identified date in 2017, that the resident was occasionally

incontinent of bowel after having been identified on the previous MDS coding completed three months earlier as being continent of bowel with complete control.
RN #106 and clinical documents confirmed that resident #005's plan of care was not reviewed or revised related to bowel incontinence when it was identified that there were no new care interventions added to the resident's plan of care over the specified period of time. (129)

iii) Resident #002's MDS and Resident Assessment Protocol (RAP) completed on an identified date in 2017, indicated that the resident had altered skin integrity. The care plan also indicated that the resident had altered skin integrity. RPN #100 and PSW #112 confirmed that the resident did not have altered skin integrity to the identified areas at the time of this inspection and have not had for greater than a year. Interview with Resident Assessment Instrument (RAI) Coordinator #110 confirmed that when resident #002's care needs changed the plan of care was not reviewed and revised. (506)

iv) The quarterly MDS continence assessment completed on an identified date in 2017, for resident #006 indicated that the resident was occasionally incontinent of bladder. The next MDS continence assessment completed three months later, indicated that the resident was totally incontinent of bladder. The plans of care in place for both time periods indicated that the resident was incontinent of bladder three or more times per week. The resident was not reassessed and there were no changes made to the plan of care when the residents care needs had changed in relation to bladder incontinence as confirmed with RAI Coordinator #102 on October 24, 2017. (156) [s. 6. (10) (b)]

4. The licensee failed to ensure that the resident's plan of care was reviewed and revised when the care set out in the plan had not been effective.

Resident #006's plan of care was not reviewed or revised and the resident continued to fall. Clinical documentation and RPN #114 confirmed that the resident was identified as a person who fell frequently. The clinical record indicated the goal of care related to falls was to reduce falls through the next review period and prevent injury from falls through the next review period. The resident fell on an identified date in March 2017, and had fallen on two identified dates in April 2017. Care interventions were in place at the end of January 2017. RPN #114 confirmed that the resident was independent, would often not comply with care directions and at the time of this inspection the resident did not have a an intervention in place because they refused to use it.
The Director of Care (DOC) and the Kinesiologist confirmed that the care interventions to manage falls and the risk for injury from falling for resident #006 had not been revised

since the end of January 2017, the resident continued to fall and no additional care interventions had been implement to address continued falling for this resident after the fall the resident experienced in March 2017. [s. 6. (10) (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 and ensuring compliance with the following requirements: the plan of care provides clear directions s. 6(1)(c), care is provided as specified in the plan s. 6(7), the resident is reassessed and the plan of care is reviewed and revised when the resident's care needs change s. 6(10)(b) and the resident is reassessed and the plan of care is reviewed and revised when the care has not been effective 6(10)(c), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or 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 plan, policy, protocol, procedure, strategy or system, was complied with.

i) In accordance with The Long Term Care Home Act2007, c. 8, s. 8(1) the licensee is to have an organized program of nursing and personal support services to meet the assessed needs of residents. In accordance with O. Reg. 79/10, s. 30(1) 1, the licensee is to have policies and procedures with respect to the organized program under section 8 of the Act.

The licensee's policy "Resident Care Documentation", located in the Nursing Manual under tab 08-06 and last reviewed on December 15, 2016, directed that "the policy is to ensure proper documentation of resident care. The chart is a legal document, therefore charting must be completed".
Clinical documentation and the DOC confirmed that staff had not ensured documentation related to the monitoring of responsive behaviours demonstrated by resident #010 was complete. Resident #010 was identified as demonstrating two responsive behaviors. A plan of care was put in place to manage one of the identified behaviours. The plan of care included directions that staff were to complete Daily Observation Sheet (DOS) documentation. The DOS form directed staff to record in half hour intervals, numbers that corresponded to resident activity. A review of the DOS form indicated staff had not documented the activity of the resident 32 times.

ii) In accordance with the Long Term Care Homes Act, 2007, c. 8 s. 8 (1)(a)(b) the licensee is required to have an organized program of Nursing and Personal Care and in accordance with O. Reg. 79/10, 30 (1) for every required program there must be written descriptions of the program that include relevant policies, procedures and protocols.
The licensee's policy "Continence" located in the Nursing Manual and located in Tab 04-29 directed "the resident's continence will be assessed annually and as necessary using the Continence Assessment Tool, with care plan updates included".
RN #106 confirmed this policy was not complied with when it was identified that the resident had become occasionally incontinent of bowel and there were no care plan updates made following documentation that the resident's bowel continence had deteriorated. [s. 8. (1) (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 and ensuring that the licensee's policies, procedures and protocols are complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

i) Resident #005 was identified as being incontinent of bowels and the resident did not receive an assessment in accordance with the requirements.

Resident Assessment Instrument (RAI) Coordinator #102 and clinical documentation confirmed that resident #005's bowel continence had deteriorated. Minimum Data Set (MDS) coding completed in March 2017, indicated that the resident was continent of bowel and had complete control. The following MDS coding completed three months later, indicated the resident was occasionally incontinent of bowel and the associated Resident Assessment Protocol (RAP) did not contain information related to the causal factors, patterns or the potential to restore function with specific interventions.
Registered Nurse (RN) #106 and RAI Coordinator #102 confirmed that generic data points selected on a Quarterly Bowel and Bladder Assessment Form completed in June 2017, did not clearly differentiate between bowel and bladder continence and this document did not identify causal factors, patterns, potential to restore function or specific care interventions as required.
RN #106 confirmed that there were no additional assessments in the plan of care related to the identified changes in bowel continence for resident #005.

ii) Resident #006 was coded as being occasionally incontinent of bladder on the June 2017, MDS assessment. The next MDS assessment completed three months later, indicated that the resident had a change in their continence level and was now incontinent. Interview with RAI Coordinator #102 on October 24, 2017, confirmed that the resident did not receive an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and that a clinically appropriate assessment specifically designed for assessment of incontinence was not completed when the resident's continence level had changed. 156 [s. 51. (2) (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 ensuring that residents who are incontinent receive an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of registered nursing staff.

Resident #007 had altered skin integrity on an identified date in 2017. Documentation in the progress notes identified the resident had altered skin integrity in the same area a month later. A review of the clinical record confirmed that the resident had not receive a weekly skin assessment over a 41 day period of time. The DOC confirmed that the altered skin integrity was not reassessed at least weekly by the registered nursing staff. [s. 50. (2) (b) (iv)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that the Residents' Council was responded to in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.
A review of the Residents' Council Meeting Minutes and interview with the Director of Recreation confirmed that not all concerns or recommendations were responded to in writing, to the council within 10 days of receipt or responded to at all.
A review of Meeting Minutes did not include written responses for the following concerns identified:
i. During the April 26, 2017, meeting concerns/recommendations were raised related to breakfast being offered later so the residents could sleep in. These concerns were responded to during the Residents' Council meeting that was held July 27, 2017.
ii. During the June 29, 2017, meeting concerns/recommendations were raised by the Council regarding staffing concerns for nursing. These concerns were not responded to in writing or responded to at the next Resident Council meeting.
iii. During the July 27, 2017, meeting concerns/recommendations were raised regarding PSW staff not being considerate with resident choices at dinner time. These concerns were not responded to in writing.
iv. During the August 29, 2017, meeting concerns/recommendations were raised regarding cups and saucers coming to the units dirty, showers not being cleaned properly, floor was slippery, there were odours when you walk in and dining room chairs were dirty. These concerns were not responded to in writing.
It was confirmed by the Acting General Manager on October 23, 2017, that responses to concerns or recommendations from Residents Council were not being completed in writing within 10 days and confirmed by the Director of Recreation that some of the identified concerns or recommendations were not responded to at all. [s. 57. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were implemented for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids, in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

On Wednesday October 18 and Thursday October 19, 2017, resident #001's wheelchair was observed by the LTCH Inspector as being dirty. The wheelchair had old food crumbs on the seat of the chair, covering the footrests and covering the bottom base in and around the wheels. Interview with RPN #100 confirmed that the wheelchairs were to be cleaned on the resident's bath days. RPN #100 confirmed that the wheelchair was dirty. [s. 87. (2) (b)]

Issued on this 11th day of December, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PHYLLIS HILTZ-BONTJE (129), CAROL POLCZ (156), LESLEY EDWARDS (506)
Inspection No. / No de l'inspection :	2017_587129_0012
Log No. / No de registre :	023882-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 16, 2017
Licensee / Titulaire de permis :	Schlegel Villages Inc 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF TANSLEY WOODS 4100 Upper Middle Road, BURLINGTON, ON, L7M-4W8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JO-ANNA GURD

To Schlegel Villages Inc, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that resident #024 and all other residents are protected from physical abuse by resident #020. The plan should be submitted via email by December 1, 2017, to Carol Polcz via e-mail at carol.polcz@ontario.ca.

Grounds / Motifs :

1. This Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. The non-compliance was issued as a CO due to a severity level of 3 (actual harm/risk) a scope of 1 (isolated) and a compliance history of 4 (ongoing non-compliance with a CO under the same section on June 12, 2015 and July 27, 2016).

In accordance with the Long Term Care Homes, 2007, Ontario Regulation 79/10, r. 2(1) physical abuse is defined as: the use of physical force by a resident that causes physical injury to another resident.

2. The licensee failed to ensure that resident #024 was protected from abuse when on an identified date 2017 resident #020 was in an physical altercation with resident #024 and as a result resident #024 sustained an injury. As per interview with the Acting Director of Care (ADOC) on October 23, 2017, staff were aware that resident #020 displayed territorial behaviour, posed a risk and had previously pushed a co-resident; however, the home did not implement any interventions to prevent a re-occurrence until after this incident.
The licensee failed to ensure that the resident was protected from physical abuse when resident #024 was injured as a result of an altercation with resident #020. (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 13, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 16th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

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