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 # / Registre no	Type of Inspection / Genre d'inspection
Aug 4, 2016	2016_343585_0011	018592-16	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 WENTWORTH HEIGHTS
1620 UPPER WENTWORTH STREET HAMILTON ON L9B 2W3

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

LEAH CURLE (585), CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), YULIYA FEDOTOVA (632)

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): June 22, 23, 24, 28, 29, 30, July 4, 6, 7, 8, 11, 2016.

Concurrent to the Resident Quality Inspection (RQI), seven additional inspections were completed, including two follow-ups from inspection #2015_2011167_004 log #008204-15 s. 6. (7) related to pain, continence and medication and log #008205-15 s. 6. (10) regarding skin and wound; one complaint log #012298-16 regarding notification, falls, infection prevention and control, responsive behaviours and continence, as well as four Critical Incident System (CIS) logs #023332-15 and #013770-16 related to abuse, log #005280-16 related to falls and log #014067-16 related to fall and injury.

During the course of the inspection, the inspector(s) spoke with residents, families, registered staff, personal support workers (PSWs), dietary staff, housekeeping staff, laundry staff, administrative staff, Kinesiologist, Resident Assessment Instrument (RAI) coordinator, Registered Dietitian (RD), Neighbourhood Coordinators, Director of Nursing (DON), Director of Food Services (DFS), Director of Environmental Services (DES), and the General Manager (Administrator).

During the course of the inspection, the inspector(s) toured the home, observed care and services provided to residents, reviewed relevant documents, including but not limited to: resident health records, menus, complaint logs, critical incident system reports/documentation, maintenance logs, policies, meeting minutes, training and quality improvement records, resident billing/charges, staffing schedules and files.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **22 WN(s)**
- **11 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
LTCHA, 2007 s. 6. (10)	CO #004	2015_201167_0004	528 581 585
LTCHA, 2007 s. 6. (7)	CO #003	2015_201167_0004	528 581 585

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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Review of the home's policies identified that when a resident has fallen, registered staff were to assess the resident using the following clinically appropriate assessment instruments:

i. The home's policy, "Fall Prevention and Management", revised February 2013, stated registered staff would assess the resident for injury and document the fall using the Falls Incident Report form. If the resident hit their head or there were no witnesses to the fall, the Head Injury Routine (HIR) was to be followed.

ii. The home's policy, "Head Injury Routine", revised January 2013, indicated that the team leader was responsible for starting the HIR immediately using the Neurological Head Injury Vital Signs Record form with all sections being completed for the following time periods: every 15 minutes, once, every 30 minutes for two hours, every hour, once and every four hours for 24 hours and every shift for two days for any known or possible head injuries and after an unwitnessed fall.

iii. The resident would be assessed each shift for 24 hours after the fall by the registered staff and a progress note would be completed on the next three shifts.

iv. A post-fall analysis would be completed by the registered staff 24 hours after the fall

occurred and the purpose of the analysis was to identify any trends that could be contributing to the fall and to determine if referral for further assessment was required.

A) During a specified period between April to June 2016, resident #022 had over 20 falls, with one resulting in an injury. Review of their plan of care identified the following:

i. A post falls assessment was not completed in the Falls Incident Report after three falls, including one fall from April 2016, that resulted in an injury.
ii. HIR was not initiated after 16 unwitnessed falls and not all sections were completed after one unwitnessed fall.
iii. The post falls follow-up note for three shifts following the fall was not completed after 12 falls.
iv. From April to June 2016, no post falls analysis was completed.

B) During a specified period between January to June 2016, resident #009 had over 15 falls. Review of the plan of care revealed the following:

i. A post falls assessment was not completed in the Falls Incident Report after two falls.
ii. HIR was not initiated after seven unwitnessed falls and after one unwitnessed fall, not all sections were completed.
iii. The post falls follow-up note for three shifts following the fall were not completed after 12 falls.
iv. From January to June 2016, no post falls analysis was completed.

C) During a specified period between February to June 2016, resident #020 had five falls with one fall resulting in an injury. Review of the plan of care identified the following:

i. HIR was not initiated after five falls.
ii. The post falls follow-up note for three shifts following the fall were not completed after three falls.
iii. From February to June 2016, no post falls analysis was completed.

D) During a specified period between March and April 2016, resident #040 had three unwitnessed falls. Review of the plan of care revealed the following:

i. HIR was not initiated after three falls.
ii. The post falls follow-up note for three shifts following the fall were not completed after three falls.

iii. No post falls analysis was completed after all three falls.

Interview with registered staff #110 and the Kinesiologist confirmed that the residents above were not assessed using a clinically appropriate assessment tool that was designed for falls as outlined in the home's Falls Prevention and Management Policy and the Head Injury Routine Policy after four residents sustained multiple falls including two falls that resulted in injury. [s. 49. (2)]

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. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication and response system was available in every area accessible by residents.

On June 22, 2016, during an initial tour of the home, the enclosed courtyard outside Carrington and Stonechurch neighbourhoods as well as the patio outside the front entrance did not contain resident-staff communication and response systems. Interview with registered staff #101 stated the patios were used by residents and families and confirmed both areas did not contain a resident-staff communication and response system. [s. 17. (1) (e)]

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 home is equipped with a resident-staff communication and response system that is available in every area accessible by residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

A) On an identified date in June 2016, resident #042 was observed with a device applied that appeared loose. Registered staff #100 confirmed that the device was too loose, then adjusted and reapplied it as per manufacturers' instruction.

B) On an identified date in July 2016, resident #042 was observed with a device applied that appeared loose. Registered staff #147 confirmed that the device was too loose and had PSW staff adjust and reapply it as per manufacturers' instruction. [s. 23.]

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 staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #4: 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. The licensee failed to ensure that the resident received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening.

On the morning of an identified date in July 2016, for six hours, resident #008 and their oral cleaning supplies were monitored. Their toothbrushes were completely dry and did not appear to be used. Review of their plan of care identified that they required total assistance with oral care. Interview with PSW #121, PSW #107, PSW #129 and PSW #128 who provided care to the resident that shift revealed that no oral care was provided. [s. 34. (1) (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 and ensuring that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes mouth care in the morning and evening, including the cleaning of dentures, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

On July 8, 2016, at approximately 1145 hours, registered staff #146 was observed walking away from their medication cart which was located the lounge outside the dining room in Carrington. The cart appeared unlocked, with residents and non-registered staff present. The Long-Term Care (LTC) Homes Inspector approached the cart, released the lock, and was able to open the drawers and access resident medications. Registered staff #146 was in another room providing medication to a resident. When registered staff #146 returned, they reported only they were to have access to the cart, that it was to be locked when unattended and confirmed they were unaware the LTC Homes Inspector opened the cart. [s. 129. (1) (a) (ii)]

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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. Every licensee shall ensure that the persons who had received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

Subsection 219. (1) of Ontario Regulation 79/10 defined intervals for the purpose of subsection 76(4) of the Act to be completed at annual intervals.

A) The licensee failed to ensure that all staff were provided annual training related to infection prevention.

Review of the home's 2015-2016 staff education logs identified that 86 per cent of all staff completed annual retraining related to infection prevention and control, which was confirmed by registered staff #101.

B) The licensee failed to ensure that all staff were provided annual training on the home's policy to promote zero tolerance of abuse and neglect.

Review of the home's annual training records indicated 70 per cent of all staff completed annual training on the home's policy to promote zero tolerance of abuse and neglect, which was confirmed by registered staff #101 and the General Manager. [s. 76. (4)]

2. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas of any other areas provided for in the regulations, at times or at intervals provided for in the regulations.

Subsection 221. (2) 1. of Ontario Regulation 79/10 defined intervals for the purpose of subsection 76 (7) of the Act to be completed at annual intervals.

A) The licensee failed to ensure that all direct care staff were provided training annually, as required under O. Reg 79/10 s. 221. (1) 1., in the area of falls prevention and management.

Information provided by the home indicated 83 per cent of direct care staff received training in falls prevention and management in 2015 and this was confirmed by registered staff #101.

B) The licensee failed to ensure that all direct care staff were provided training annually, as required under O. Reg 79/10 s. 221. (1) 2., in the area of skin and wound care.

Review of the home's 2015-2016 staff education records identified that 76 out of 97 direct care staff received training related to skin and wound care. Interview with registered staff #101 revealed additional face to face education was completed in 2015; however, a total of 79 per cent of direct care staff completed education related to skin and wound.

C) The licensee failed to ensure that all direct care staff were provided training annually, as required under O. Reg 79/10 s. 221. (1) 3., in the area of continence care and bowel management.

Review of the home's 2015-2016 staff education records identified that 76 out of 97 direct care staff completed online mandatory training regarding continence care and bowel management. Interview with registered staff #101 confirmed that an additional three staff members completed face to face education; however, the total staff who

received annual continence care and bowel management was 81 per cent.

D) The licensee failed to ensure that all staff who apply PASDs or who monitor residents with PASDs, were provided training annually, as required under O. Reg. 79/10 s. 221. (1) 6 in the area of the application, use and potential dangers of PASDs.

Information provided by the home indicated 64 per cent of direct care staff received training in minimizing of restraints and PASDs in 2015, and was confirmed by registered staff #101. [s. 76. (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 and ensuring that the persons who have received training under subsection 76. (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations; and, all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in paragraph 6 of subsection 76 (7), at times or at intervals provided for in the regulations, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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 there was a written plan of care for each resident that sets out the planned care for the resident.

A) On an identified date in February 2016, resident #020 fell and sustained an injury that required the application of a device. Interview with Personal Support Worker (PSW) #105 stated the device was applied during the day and removed at night by staff. Review of the written plan of care indicated the resident required the device in the day and at night; however, the personal care observation and monitoring form did not indicate that the resident required the device and was not documented by the PSW staff as planned care. Registered staff #110 confirmed that the application of device was planned care and it was not documented on the PSW flow sheets.

B) On an identified date in April 2016, resident #022 fell and sustained an injury. Review of the progress notes identified that when the resident was restless, staff would implement fall prevention strategies. Review of the written plan of care did not identify that the resident could be restless, nor did it include all interventions that were documented in the progress notes. Interview with registered staff #145 and PSW #145 both stated the interventions identified in the progress notes was planned care for the resident and confirmed that the written plan of care did not set out the planned care for the resident.

C) Review of resident #010's plan of care, including MDS assessments from February and May 2016, their written care plan, as well as their personal profile did not state that they wore a device. On an identified date in June 2016, resident #010, PSW #118 and registered staff #106 reported the resident wore the device and staff confirmed the written plan of care did not contain information about the resident's planned care. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A) Resident #003's written plan of care stated they were to receive a dietary intervention three times a day. On an identified date in June 2016, during a meal observation, the resident did not receive the dietary intervention. Review of the dietary serving notes did not include the dietary intervention. Interview with PSW #124 and the Registered Dietitian (RD) reported the resident was to receive the intervention once a day and confirmed the written plan of care did not set out clear direction to staff.

B) Resident #082's written plan of care stated they required extensive assistance for toileting by two staff. Review of an adjustment to their plan of care as a part of huddle communication stated staff were to assist the resident to the washroom every four hours,

or as needed, and re-approach at another time if sleeping or if they did not want to use the toilet. Interview with PSW #134 who reported the resident needed to be checked every two to three hours for their toileting needs; however, PSW #107 reported the resident was to be checked every three to four hours. Registered staff #106 reported the resident was to be toileted upon getting up in the morning, before and after meals. The plan of care did not provide clear directions to the staff related the resident's needs for toileting. [s. 6. (1) (c)]

3. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A) Resident #012's Minimum Data Set (MDS) assessments, completed in February and May 2016, indicated under Section G: Physical Functioning and Structural Problems that they were bedfast all or most of the time. Review of their written plan of care revealed they received care with a sit to stand lift and participated in activities. During the inspection, the resident was observed seated in an upright position at meals. Interview with registered staff #111 stated that they were positioned upright for their meals and snacks and was seated upright for over two hours on the day shift. Interview with registered staff #110 confirmed that the resident was not bedfast all or most of the time and that the assessments were not consistent with each other.

B) Resident #004's full MDS assessment, completed in February 2016, indicated under Section G: Physical Functioning and Structural Problems that they were bedfast all or most of the time. During the MDS assessment review date (ARD) period, a progress note in the resident's clinical record noted they were up for meals. Interview with registered staff #103 reported the resident was ill during the ARD period; however, would sit up in a chair. Registered staff #116 reported the resident was not continually in bed when they were ill. Interview with registered staff #110 reported the resident became ill a few days before the end of the ARD period, that the resident was not bedfast all or most of the time and the assessments were not consistent with each other.

C) Resident #004's MDS assessments, completed in March and June 2016, indicated that they were bedfast all or most of the time. Review of their written plan of care which indicated they walked independently with a mobility device, performed activities of daily living (ADL's) independently and were up in the dining room for meals. During the course of this inspection, the resident was observed up during and in between meals.

Interview with registered staff #103 stated the resident got up when they wanted and stated they up longer than two hours a day. Interview with registered staff #110 confirmed that resident #002 was not bedfast all or most of the time and that the assessments were not consistent with each other.

D) On an identified date in February 2016, resident #020 fell, was sent to hospital and diagnosed with an injury. Review of their plan of care indicated there was a significant change in their condition post-fall related to a change the assistance they required for their ADL's; however, the MDS assessment completed upon their return from hospital was not completed as a significant change in status assessment. Interview with registered staff #110 stated the resident had a significant change in status after the fall and the MDS assessment and return from hospital assessment were not consistent with each other. [s. 6. (4) (a)]

4. The licensee failed to ensure that the substitute decision maker was provided the opportunity to fully participate in the development and implementation of the plan of care.

In 2015, the home arranged a communication plan with resident #040's substitute decision maker (SDM) in attempt to keep them informed of the resident's status. The SDM reported in an interview that the home did not communicate with them as per the plan and this was confirmed by registered staff #101. [s. 6. (5)]

5. The licensee failed to ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

Registered staff #101 reported information regarding continence product used by residents was listed on a Medical Mart continence list located in yellow continence binders in each neighbourhood.

Review of the continence lists in the continence binders on Carrington, Stonechurch and Scotsdale did not include all residents' continence product requirements, as the lists were not up-to-date. PSW #140, who was not a regular staff, stated they would be dependent on regular staff to inform them what continence product residents required. Registered staff #101 reported the most up-to-date list was located in the green continence binder and was to be distributed to each neighbourhood; however, confirmed that staff did not have convenient and immediate access to information regarding resident continence product needs as the lists were outdated. [s. 6. (8)]

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

A) Resident #012's written plan of care indicated that they were transferred using a mechanical lift or a sit to stand lift. Review of the Program of Activity Living (PAL) Transfer and Lift Decision assessment, completed in June 2016, identified the resident was a total mechanical lift for all transfers. Interview with registered staff #111 stated the resident was a mechanical lift for all transfers and confirmed the written plan of care was not reviewed and revised when their care needs changed.

B) Resident #022's written plan of care related to falls interventions indicated they required two devices. Interview with PSW #127 stated a different falls intervention strategy was used as per family request and the resident no longer used two devices. Interview with the Kinesiologist confirmed that the resident's plan of care was not reviewed and revised when their care needs changed.

C) In 2016, resident #008 was admitted to the home. Approximately a month later, the resident was assessed by a dentist and the home was provided new direction to staff regarding their oral care regimen. Review of the resident's written plan of care and personal care profile did not include the new oral care/dental cleaning regimen. Interview with PSW #138 and PSW #128 both identified that it was sometimes difficult to complete oral care and PSW #138 was not aware of the direction made by the dentist. The written care plan and personal care profile was not updated to include the direction from the dentist and staff were unaware of the new oral care regimen.

D) During the course of the inspection, resident #011 was observed not wearing visual appliances. MDS assessments completed in January, April and July 2016, indicated the resident did not wear visual appliances; however, their written plan of care contained the information that they used them. Interview with PSW #121 reported the resident no longer wore the appliances and registered staff #120 confirmed the plan of care was not reviewed and revised when the resident's care needs changed.

E) Resident #040's plan of care indicated they required two falls prevention interventions. Review of their progress notes identified that a third falls prevention measure was also used; however, their written plan of care did not include the third intervention. Interview with registered staff #110 stated the resident required the third falls prevention intervention and confirmed the written plan of care was not reviewed and

revised when the intervention was put in place.

F) Resident #020's plan of care indicated they required one bed rail. Review of the PAL Transfer and Lift Decision assessment from June 2016, identified that the resident was able to hold onto the bed rail in bed to assist with standing. Interview with PSW #142 and observation of the resident's bed revealed they did not have bed rails. Registered staff #101 stated the resident did not have bed rails and confirmed that the written plan of care was not reviewed and revised when bed rails were no longer necessary.

G) On an identified date in February 2016, resident #020 fell and sustained an injury. Review of their plan of care indicated they had a significant change in status; however, the written plan of care revealed that it was not updated until over a week later, which was confirmed by registered staff #110.

H) The home's policy, "Nutrition and Hydration", revised April 2014, stated any resident who has a fluid intake less than their estimated fluid requirement will be reported to the oncoming Registered Practical Nurse/Registered Nurse (RPN/RN) so that interventions can be initiated. The RPN/RN will assess signs and symptoms of dehydration by completing the Dehydration Risk Assessment Tool if fluid intake is less than 1000 millilitres per day (mL/day). The Dehydration Risk Assessment Tool also stated if the resident does not experience symptoms of dehydration to continue fluid monitoring and assess again in three days if the resident continues to consume less than 1000 mL/day consecutively for three more days.

i) In April 2016, for four consecutive days, resident #040's total daily fluid intake was less than 1000 mL/day. No Dehydration Risk Assessment Tool was completed as confirmed by the Director of Nursing (DON).

ii) In April 2016, for 10 consecutive days, resident #040's total daily fluid intake was less than 1000 mL/day. No Dehydration Risk Assessment tool was completed during this time, when it would be expected three times over 10 days, as confirmed by the DON. Interview with PSW #131 and PSW #127 who reported the resident's fluid intake was low in April 2016, which was abnormal. The DON confirmed the resident was not reassessed when their care needs changed regarding ensuring an adequate hydration status. [s. 6. (10) (b)]

7. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set

out in the plan of care had not been effective.

In February 2016, resident #022 was identified at risk of falling and fall prevention interventions were put in place. Review of the plan of care identified that the resident fell 13 times over approximately two months, with the thirteenth fall resulting in injury. Additional fall prevention interventions were not put into place until after the injury. Following the injury, the resident experienced 18 additional falls until a new intervention was implemented in June 2016. Interview with the DON and registered staff #110 confirmed that a post falls analysis was not completed for any of the falls as required by the home's Falls Prevention and Management policy, to identify trends and therefore did not determine additional actions and interventions to prevent resident #022 from falling. The plan of care was not revised after resident #022 fell multiple times and the interventions in place had not been effective in preventing them from falling [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 ensuring that staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary or care set out in the plan has not been effective, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service that included, at a minimum, providing residents with personal assistance to safely eat and drink as comfortably and independently as possible.

On an identified date in June 2016, during a meal, PSW #137 was observed standing while assisting resident #043 and resident #045 with eating. PSW #124 was observed standing while providing assistance to resident #044. PSW #124 reported staff were to be seated when assisting the residents, which was confirmed by the RD. [s. 73. (1) 9.]

2. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

On an identified date in July 2016, during a nourishment pass, PSW #119 was observed standing while providing total assistance with eating to resident #041. The resident's head and torso were reclined. Registered staff #116 reported the resident was at risk for choking and confirmed the resident should have been upright and the PSW seated while assisting them. [s. 73. (1) 10.]

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 home has a dining and snack service that includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #9: 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 failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcer, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On an identified dates in June and July, 2016, an observation of resident #012 revealed that they had a skin tear. Review of their plan of care revealed there was no assessment of the skin tear. Interview with registered staff #106 confirmed an assessment of the skin tear should have been completed using the home's wound assessment tool or in a progress note; however, was unable to find a completed assessment of the skin tear. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

In March 2016, resident #082 had a fall resulting in a new area of altered skin integrity. Review of the plan of care did not include weekly wound assessments until May 2016, when family reported concerns about the wound worsening. Interview with registered staff #106 confirmed that the wound from May 2016, was the same wound from March 2016. A treatment plan was put into place until the wound was documented as healed later in May 2016. Registered staff #106 confirmed weekly wound assessments were not competed from March to May 2016. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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 and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee shall ensure that all staff participate in the implementation of the program.

The home's policy, "Hand Hygiene", dated April 2013, identified "4 Moments of Hand Hygiene" when working with residents of health care setting and directed staff to complete hand hygiene before contact with resident or their environment, before aseptic procedures, after body fluid exposure risk, and after resident or environmental contact.

A) On June 22, 2016, during lunch in the Carrington dining room, PSW #123 was observed serving meal courses, touching soiled dishes and cutlery and a resident's hand without completing hand hygiene. PSW #123 reported there was no expectation to conduct hand hygiene between clearing dishes and serving new courses unless their hands were visibly soiled or someone was sick. The Director of Food Services confirmed the home's expectation was that hand hygiene be conducted between clearing soiled dishes and serving new courses.

B) On an identified date in July 2016, registered staff #106 was observed administering medications to four residents, including but not limited to: pills, eye drops, subcutaneous insulin. During the observation, registered staff also transported a resident into the dining room and handled a resident's shoe. Registered staff #106 did not complete hand hygiene at any time during the observation. Interview with registered staff #106 and #107 identified that hand hygiene was to be completed between residents when administering medications. [s. 229. (4)]

Additional Required Actions:

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

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a registered dietitian who was a member of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

Based on the home's occupancy of 120 residents, the RD was required to work a minimum of 60.00 hours per month, as confirmed with the RD. Review of the RD's nutrition service invoices from January to June 2016 revealed they had not worked the minimum required hours per month, and only 12.50 hours were made up during the identified period.

i. January 2016 - 44.5 hours
ii. February 2016 - 58.0 hours
iii. March 2016 - 72.5 hours
iv. April 2016 - 44.0 hours
v. May 2016 - 56.0 hours
vi. June 2016 - 60.0 hours

The RD confirmed they had not worked 60.00 hours per month in the home and had not requested back-up when they were unable to meet their required hours. The RD reported they had a plan in place to make up for the hours in July and August 2016; however, as of July 1, 2016, the home was short 25.00 hours by a RD for clinical and nutrition care duties. [s. 74. (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 and ensuring that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties, to be implemented voluntarily.

WN #12: 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).**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent received an assessment that included the 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 required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

The home's policy, "Continence", revised January 2013, stated upon admission each resident would have a continence assessment completed using the Resident Assessment Instrument (RAI) MDS tool including a seven day observation period, in combination with a "Admission Bowel and Bladder Assessment Form" and a detailed three day voiding and bowel elimination record to allow the resident and team to create a plan of action and individualized care plan.

A) Resident #008 was admitted to the home in 2016. Review of the plan of care identified that they were incontinent and required the use of a continent product. The plan directed staff to check and change the resident at regular intervals and to use a specific continence product.

On admission, a three day voiding diary was not completed for the resident, as confirmed by registered staff #106. Registered staff #130 identified that the SDM was working with the direct care staff and determined a continence product and an additional intervention would be used for containment.

On an identified date in July 2016, the resident was wearing a continence product along with more than one additional intervention for containment. Interview with PSW #121 identified that, although this was not a routine practice of the home, additional interventions were implemented as per SDM request. Further observations identified that the continence product and additional interventions did not keep the resident clean and dry. Interview with part time staff PSW #138 and PSW #119 revealed that they only used the continence product, not the two additional interventions and checked the resident often.
An assessment of the resident's patterns of incontinence, when using the continence product had not been completed, to assist the SDM and multidisciplinary staff to create a plan to manage the resident's incontinence to keep them clean and dry.

B) Resident #001 was admitted to the home in 2016. Review of their clinical record revealed that a three day voiding and bowel elimination record to identify patterns of incontinence not completed. Their plan of care for continence also stated directed staff to complete a voiding diary to assess for a continence product and refer to the prevail list. Review of the home's most recent prevail (continence product) list, dated June 7, 2016, stated the resident was continent and did not use continence products. PSW #131 reported the resident wore a continence product. Registered staff #110 confirmed a three day voiding diary was not completed; therefore, the continence assessment did not include patterns of incontinence. [s. 51. (2) (a)]

2. The licensee failed to ensure that the resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that plan was implemented.

Resident #008's plan of care identified they required assistance with toileting and continence care. The plan also indicated they were incontinent, directed staff to check and change every four hours, and highlighted an indicator specific to the resident that would suggest to staff that they required continence care. Observations made on an identified date in July 2016, confirmed that the plan for the resident related to bladder continence was not implemented.

On an identified date in July 2016, resident #008 was monitored for six hours. At approximately the third hour of observation, they demonstrated the indicator to suggest they may require continence care. The resident was not checked and changed until over six hours, at which time the resident's continence products were soaked with urine and did not provide effective containment. The resident #008's plan of care to be changed at a minimum of every four hours was not implemented. [s. 51. (2) (b)]

3. The licensee failed to ensure that there were a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes.

During the inspection, dry utility rooms in Carrington, Scotsdale and Stonechurch neighbourhoods did not contain pull-up type incontinence products. Interviews with regular staff, including registered staff #106, PSW #131, PSW #127 and PSW #105 all reported pull-up products were considered specialty product, ordered by the home only for specific residents and stored in their individual washrooms. PSW #127 and #131 reported residents did not receive pull-up products unless requested by family.

Tour of the dry storage room in the basement revealed several boxes of pull-up style continence products which were labelled for specific residents. Four unlabelled individual packages of size large pull-up products were also observed; however, regular registered staff #106 reported the staff would not necessarily use the unlabelled individual packages on anyone. Furthermore, no size small pull-ups were observed.

Interview with the DON who reported pull-ups were only ordered for specific residents once they had an identified need for pull-ups were only to be supplied to the identified

resident. The DON confirmed when residents were initially admitted to the home, pull-up type product were not available and accessible to residents and staff at all times, and in sufficient quantities for all required changes, as they did not keep a general supply of pull-ups in the home for staff to use. [s. 51. (2) (f)]

4. The licensee failed to shall ensure that residents were provided with a range of continence care products that were based on their individual assessed needs, promoted resident comfort, ease of use, dignity and good skin integrity, continued independence wherever possible, and were appropriate for the time of day, and for the individual resident's type of incontinence.

A) PSW #131 and PSW #145 reported resident #001's family purchased their continence products and had not been trialed in a pull-up product, which was confirmed by the resident's SDM. The SDM reported it was their understanding family had to provide pull-up style products. PSW #131 and the SDM reported the resident was able to toilet independently with cueing.

B) PSW #131 and PSW #145 reported resident #047's family purchased their continence products, which was confirmed by the SDM. PSW #131 and #145 reported the resident was able to toilet independently. One family member reported a pull-up type product was most comfortable for the resident.

Interview with the DON and registered staff #101 reported the home was able to supply a range of continence care products including pull-ups; however, were unaware resident #001 and #047 were not offered or trialed in the home's pull-up product. [s. 51. (2) (h)]

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 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; each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; and that residents are provided with a range of continence care products that, are based on their individual assessed needs, properly fit the residents, promote resident comfort, ease of use, dignity and good skin integrity, promote continued independence wherever possible, and are appropriate for the time of day, and for the individual resident's type of incontinence, to be implemented voluntarily.

WN #13: 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 the plan, policy, protocol, procedure, strategy or system was complied with.

A) The home's policy, "Continence", dated January 2013, directed the home to complete monthly audits to ensure that the continence product for residents had been applied properly, correctly sized, and the product provided comfort and met the needs of the resident.

i. Interview with registered staff #101 confirmed that monthly audits were not completed related to residents' continence products, as required in the home's policy.

ii. Review of the home's annual quality review for the continence policy, dated February 6, 2015, documented under learnings and actions that monthly audits were not being conducted.

B) The home's policy, "Weight and Height Monitoring", revised August 2015, stated height will be measured annually and entered into the Village Software.

On June 22, 2016, during a record review the home's facility height report, printed from the Village software program 'GoldCare' , revealed 68 out of 120 residents had either no height entered or an updated height entered since January 1, 2015. Registered staff #110 reported annual heights were to be recorded and entered into the home's software and confirmed they were not completed for all residents. [s. 8. (1) (b)]

WN #14: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During the inspection, carpeting in the Carrington was noted to have offensive lingering odours and staining, particularly in the area near the shower room. Interviews with PSW #122, PSW #127, PSW #131 and PSW #132 who all reported several residents were known to void on the carpeted areas through the neighbourhood, and despite cleaning by housekeeping, odours remained.

Interview with the Director of Environmental Services (DES) who reported the carpets received a deep clean every four weeks and as needed; however, despite being cleaned by the home on July 4, 2016, and on July 8, 2016, by a professional cleaner, the odours remained. The DES reported the carpeting had been in the home area for several years, and there was no plan to replace or remove carpeting specifically near the shower room. [s. 15. (2) (c)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a registered dietitian who was a member of the staff of the home completed a nutritional assessment for all residents on admission and assessed the matters referred to in paragraphs 13 and 14 of subsection (3).

Resident #001 was admitted to the home in 2016. Review of their clinical record revealed that the RD did not assess the resident on admission, including their nutritional status, height, weight, any risks relating to nutrition care, hydration status and any risks relating to hydration until five weeks after their admission. As outlined in Ontario Regulation 79/10, s. 25 (1), the licensee was required to ensure that assessments necessary to develop an initial plan of care under subsection 6 (6) of the Act were completed within 14 days of the resident's admission and the initial plan of care developed within 21 days of the admission. The RD confirmed they did not assess the resident within 21 days of their admission. [s. 26. (4)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of Ontario Regulation 79/10: the program was evaluated and updated at least annually in accordance with evidence-based practices and, if none, in accordance with prevailing practices.

The General Manager confirmed the home did not complete an annual evaluation of their falls prevention and management program in 2015. [s. 30. (1)]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) The home's program for skin and wound care directed staff to complete, on an ongoing basis, the skin assessment, by PSWs, typically on each bath day. Staff were to record on the resident's flow sheets if no concerns need to be addressed, and if a concern was identified, it was to be documented using the Twice Weekly Skin Assessment Form and a Skin Assessment Concerns Form, and given to the Registered staff.

In May 2016, resident #008 had a new area of altered skin integrity identified by staff which was treated and was documented as resolving the following week.

i. Review of the resident's flow sheets during a period between May and June 2016, did not include documented Skin Assessments by PSWs or completed Twice Weekly Skin Assessment Forms. Interview with registered staff #106 and registered staff #130 confirmed that PSW staff did not document twice weekly skin assessments as required by the home's skin and wound program.

ii. The resident's plan of care directed staff to reposition and document on the repositioning monitoring form. Review of progress notes identified that as a result of altered skin integrity, the resident remained in bed during identified dates in May 2016. On some of the identified dates, the repositioning record was not completed on all shifts. Interview with registered staff #106 and registered staff #130 confirmed that PSW staff did follow the resident's plan of care; however, did not document resident repositioning as required.

B) Resident #012's plan of care identified that they were to be repositioned every two hours and care documented on the Repositioning Record. Review of the Repositioning Record revealed documentation was not completed on all shifts on four days in June 2016. Interview with registered staff #106 stated PSWs were to document when they repositioned the residents on all shifts and stated that the resident was repositioned but confirmed that the interventions were not documented on the specified dates. [s. 30. (2)]

WN #17: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

On an identified date in June 2016, resident #081 was observed with a PASD applied, as reported by PSW #108 and registered staff #111. Review of the resident's clinical record revealed they received a PASD on an identified date in May 2016; however, there was no documented information in the plan of care about the use of the PASD until the end of June 2016, which was confirmed by registered staff #110. [s. 33. (3)]

2. The licensee failed to ensure the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living was included in a resident's plan of care only if all of the following were satisfied:

1. Alternatives to the use of a PASD had been considered and tried where appropriate.
3. The use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, or any other person provided for in the regulations.
4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

A) On multiple days during the course of the inspection, resident #012 was observed sitting in their tilt wheelchair in the tilted position. Registered staff #107 and PSW #106 stated the resident was in the tilt wheelchair for positioning and comfort and to assist them with activities of daily living. Review of their clinical record revealed no documented assessment for the use of the tilt wheelchair as a PASD, nor any documented consent or approvals for its use. Registered staff #110 confirmed that the tilt wheelchair was not assessed as a PASD, nor did they have documented consent or approval for its use. (581)

B) On an identified date in July 2016, resident #022 was observed tilted in a wheelchair. Review of their written plan of care identified that they were using the chair for comfort, repositioning and pressure as a PASD. Review of progress notes identified the resident was transferred to the chair in April 2016. Review of the clinical record indicated that there was no documented assessment or approval for the use of the wheelchair as a PASD until May 2016, nor any documented consent for its use. Registered staff #110 stated the resident was positioned in the wheelchair for comfort and positioning and confirmed that the tilt wheelchair was not assessed as a PASD and there was no documented consent or approvals for its use when the resident was initially positioned in the wheelchair.

C) On identified dates in June 2016, resident #003 was observed tilted in their wheelchair. A few days before the observation dates, review of the Alternative to PASD/Restraint Assessment and written plan of care identified the resident required a tilt wheelchair as a PASD for comfort and repositioning. Review of the plan of care revealed no documented consent for the tilt wheelchair as a PASD, which was confirmed by registered staff #117.

D) On identified dates in June 2016, resident #009 was observed sitting in the tilted wheelchair. Review of the Alternative to PASD/Restraint Assessment completed in May 2016, as well as the written plan of care identified they required a tilt wheelchair as a PASD for comfort, repositioning and pressure. Review of the plan of care revealed no documented consent for the tilt wheelchair as a PASD which was confirmed by registered staff #116. [s. 33. (4)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

On an identified date in June 2016, resident #010's glasses were observed unlabelled. Interview with PSW #118 and registered staff #106 confirmed the resident wore glasses and the home did not label glasses. The DON confirmed the home did not have a policy on labelling glasses and did not label them. [s. 37. (1) (a)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

In February 2016, resident #020 fell, was sent to hospital and returned to the home with an injury. Review of the plan of care identified that no pain assessment was completed upon return from hospital. The following day, new orders were made for pain and directed staff to complete a pain assessment every shift for seven days. Review of the Medication Administration Record from February 2016, revealed that the pain assessment was not completed on nine shifts over seven days.

The home's policy, "Readmission", reviewed January 2013, required registered staff to complete a pain assessment when a resident returned from hospital. The home's "Pain Management Program", revised November, 2015, required that registered staff complete and document a pain assessment using the Abbey Pain Scale and when a new analgesic was started.

Interview with registered staff #116 confirmed that the Abbey Pain Scale assessment was not completed upon return from hospital as required in the policy, nor were the seven day pain assessments consistently completed on all three shifts. [s. 52. (2)]

WN #20: The Licensee has failed to comply with LTCHA, 2007, 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 licensee responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Review of Resident's Council meeting minutes from November 2015, revealed that Council raised concerns related to room cleaning and the flu season. A Residents' Council Communication Form was completed and directed to the appropriate team members, and as well, an invitation to a following meeting was requested. Review of the Residents' Council minutes did not include a response to the Council by the licensee. It was identified in February 2016, that the Council still had questions and were requesting information related to outbreaks and the flu season. A Communication form was completed and directed to the appropriate staff member, inviting them to attend the March 2016 meeting. A response was provided to the Council, and the invitation was accepted; however, the concerns were not addressed at the next meeting. Review of the meeting minutes and interview with staff #141 confirmed that the concerns identified above had not been addressed. [s. 57. (2)]

WN #21: 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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

The home's procedure, "Odour Control", revised October 2011, stated incidents of offensive odours were to be addressed by using automatic deodorizers/odour eliminators in high odour areas, provide an odour control product to team members to use when necessary, regular fabric and carpet care, and automatic/regular use of exhaust fans/systems throughout the village.

During the course of the inspection, lingering offensive odours were noted coming from carpeting in the Carrington neighbourhood, particularly the area close to the shower room. On multiple occasions, the carpet appeared wet and stained. Interview with PSW #122, PSW #127, PSW #131 and PSW #132 who all reported some residents were known to void on the carpeted areas through the neighbourhood, and despite cleaning by housekeeping, the odours remained.

On July 7, 2016, interview with the DES who reported the carpets received a deep clean every four weeks and as needed if there was a need for the carpet to be cleaned. Review of the maintenance log revealed the carpets were deep cleaned July 4, 2016; however, offensive lingering odours remained on July 6 and 7, 2016, and no request was made for cleaning during that time. The DES confirmed that there was no odour eliminator in the area near the shower room, no carpet care completed since July 4, 2016 , and that the exhaust system was not working in the hallway by the tub room. On July 8, 2016, a professional cleaner cleaned the carpets the night before; however, the odour was still present after the cleaning. [s. 87. (2) (d)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented to ensure that the heating, ventilation and air conditioning systems were in good state of repair.

On July 6, 2016, interview with PSW #132 who reported the ventilation in the shower and tub rooms in Carrington was poor had not been working for some time. Interview with the DES who reported the home's process for reporting maintenance concerns was through their electronic maintenance request system, as outlined in their maintenance requisitions policy. Review of the requisition log from April to July 2016 revealed maintenance requests were submitted regarding the tub room ventilation. On May 25, 2016, a maintenance request was submitted for the shower room ventilation; however, no maintenance request had been submitted since that time. The DES reported they were unaware of there ever being issues with the ventilation in the Carrington shower and tub rooms and required outside contractors to inspect the ventilation system. (585) [s. 90. (2) (c)]

Issued on this 15th day of August, 2016

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) :	LEAH CURLE (585), CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), YULIYA FEDOTOVA (632)
Inspection No. / No de l'inspection :	2016_343585_0011
Log No. / Registre no:	018592-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 4, 2016
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 WENTWORTH HEIGHTS 1620 UPPER WENTWORTH STREET, HAMILTON, ON, L9B-2W3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	VANDA KOUKOUNAKIS

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee shall ensure that:

A) When a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls as outlined in the home's Falls Prevention and Management Policy and the Head Injury Routine Policy.

B) All registered staff receive re-education in falls prevention and management, specifically, but not limited to:
- the rationale, process and expectation to assess all falls,
- where the condition or circumstances of the resident require, when, why and how to conduct a post-fall assessment using a clinically appropriate assessment instrument which includes completing the post falls analysis, post falls notes every shift for 24 hours after the fall and Head Injury Routine (HIR) is completed after every fall, if a resident hits their head or there are no witnesses to the fall.
- ensuring staff are able to and identify any trends that could be contributing to each fall and to determine if referral for further assessment is required or at anytime when care set out in a resident's plan of care has not been effective.

C) Processes and schedules are implemented for monitoring staff's compliance in completing post-fall assessments appropriately.

D) Interdisciplinary processes for monitoring and analyzing falls are implemented.

Grounds / Motifs :

1. The non-compliance issued was determined to have a severity of 'actual harm', a scope of 'isolated' with a history of 'unrelated' non-compliance.

2. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Review of the home's policies identified that when a resident has fallen, registered staff were to assess the resident using the following clinically appropriate assessment instruments:

i. The home's policy, "Fall Prevention and Management", revised February 2013, stated registered staff would assess the resident for injury and document the fall using the Falls Incident Report form. If the resident hit their head or there were no witnesses to the fall, the Head Injury Routine (HIR) was to be followed.

ii. The home's policy, "Head Injury Routine", revised January 2013, indicated that the team leader was responsible for starting the HIR immediately using the Neurological Head Injury Vital Signs Record form with all sections being completed for the following time periods: every 15 minutes, once, every 30 minutes for two hours, every hour, once and every four hours for 24 hours and every shift for two days for any known or possible head injuries and after an unwitnessed fall.

iii. The resident would be assessed each shift for 24 hours after the fall by the registered staff and a progress note would be completed on the next three shifts.

iv. A post-fall analysis would be completed by the registered staff 24 hours after the fall occurred and the purpose of the analysis was to identify any trends that could be contributing to the fall and to determine if referral for further assessment was required.

A) During a specified period between April to June 2016, resident #022 had over 20 falls, with one resulting in an injury. Review of their plan of care identified the following:

i. A post falls assessment was not completed in the Falls Incident Report after three falls, including one fall from April 2016, that resulted in an injury.
ii. HIR was not initiated after 16 unwitnessed falls and not all sections were completed after one unwitnessed fall.
iii. The post falls follow-up note for three shifts following the fall was not completed after 12 falls.
iv. From April to June 2016, no post falls analysis was completed.

B) During a specified period between January to June 2016, resident #009 had over 15 falls. Review of the plan of care revealed the following:

i. A post falls assessment was not completed in the Falls Incident Report after two falls.

ii. HIR was not initiated after seven unwitnessed falls and after one unwitnessed fall, not all sections were completed.
iii. The post falls follow-up note for three shifts following the fall were not completed after 12 falls.
iv. From January to June 2016, no post falls analysis was completed.

C) During a specified period between February to June 2016, resident #020 had five falls with one fall resulting in an injury. Review of the plan of care identified the following:

i. HIR was not initiated after five falls.
ii. The post falls follow-up note for three shifts following the fall were not completed after three falls.
iii. From February to June 2016, no post falls analysis was completed.

D) During a specified period between March and April 2016, resident #040 had three unwitnessed falls. Review of the plan of care revealed the following:

i. HIR was not initiated after three falls.
ii. The post falls follow-up note for three shifts following the fall were not completed after three falls.
iii. No post falls analysis was completed after all three falls.

Interview with registered staff #110 and the Kinesiologist confirmed that the residents above were not assessed using a clinically appropriate assessment tool that was designed for falls as outlined in the home's Falls Prevention and Management Policy and the Head Injury Routine Policy after four residents sustained multiple falls including two falls that resulted in injury. [s. 49. (2)] (581)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2016

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
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 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 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, 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 4th day of August, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Leah Curle

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