Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 21, 2015	2015_201167_0006	H-002113-15	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH SYSTEM
56 GOVERNOR'S ROAD DUNDAS ON L9H 5G7

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

ST JOSEPH'S VILLA, DUNDAS
56 GOVERNOR'S ROAD DUNDAS ON L9H 5G7

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

MARILYN TONE (167), BERNADETTE SUSNIK (120), JESSICA PALADINO (586), LESLEY EDWARDS (506), YVONNE WALTON (169)

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): March 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 30, 31, April 1, 14, 15, 16, 17, 2015.

The following inspections were completed simultaneously with this Resident Quality inspection:
Complaint Logs: H-000777-14, H-000891-14, H-001026-14, H-001069-14, H-001158-14, H-001151-14, H-001172-14, H-001174-14, H-001245-14, H-001525-14, H-001566-14, H-001612-14, H-001909-15, H-001981-14, H-002087-15 and H-002139-15.
Critical Incident Logs; H-00776-14, H-000800-14, H-001353-14, H-001798-15, H-001810-15.
The following Follow-Up Inspections were completed during this review; H-001900-15, H-000941-14, H-000695-14, H-000696-14, H-000942-14, H-000943-14, H-000945-14, H-000388-13, H-000557-14, H-000936-14.

During this review, the inspectors conducted tours of the home, observed resident care on all three shifts, reviewed relevant policies and procedures, resident health records, investigation notes completed by the home, minutes of meetings menus, recipes, production sheets and other relevant documents.

During the course of the inspection, the inspector(s) spoke with the President, Director of Care (DOC), Assistant Directors of Care (ADOC), Resident Care Coordinator (RCC), Resident Assessment Instrument Coordinator (RAI Coordinator), Manager of Quality and Performance, Nursing Assistant, Food Services Manager (FSM), Housekeeping/Laundry/Security Supervisor, Registered Dietitians, Admissions Coordinator, Infection Control Nurse, registered nurses (RNs), registered practical nurses (RPNs) and personal support workers(PSWs), Behavioural Support Unit Representative, Therapeutic Recreation Lead, Finance Clerk, identified residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Training and Orientation
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
- **19 WN(s)**
- **8 VPC(s)**
- **9 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.O. 2007, c.8 s. 101. (4)	CO #006	2014_188168_0014	167
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #001	2014_189120_0079	120
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #002	2014_189120_0079	120
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2014_188168_0014	167
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2014_250511_0020	167
LTCHA, 2007 S.O. 2007, c.8 s. 30. (1)	CO #005	2014_188168_0014	167
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #003	2014_188168_0014	167
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #004	2014_188168_0014	167
O.Reg 79/10 s. 73. (1)	CO #010	2014_188168_0014	167
O.Reg 79/10 s. 87. (2)	CO #005	2014_189120_0079	120
O.Reg 79/10 s. 87. (3)	CO #006	2014_189120_0079	120
O.Reg 79/10 s. 91.	CO #003	2014_189120_0079	120

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. 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. A) The licensee has failed to ensure that the policy named "Medication administration record (MAR)" was complied with.
The policy directed staff to document on the reverse side of the MAR (medication administration record) including reason for giving the medication and the effectiveness of the PRN (when required) dose. Resident #333 received a narcotic pain medication nine times in February 2015 for pain. The effectiveness of the medication was not documented on the reverse side of the MAR eight out of nine times. The same resident received one dose of the same medication in December 2014 and three times in March 2015 for pain. The effectiveness of the medication was not documented on the reverse side of the MAR sheet for both months. This was confirmed by the registered nursing staff and documentation.

B) The licensee failed to ensure that the policy named "Ordering and receiving medications from the pharmacy" was complied with.
The policy directed staff to record the following for information for every drug order: residents name, drug name, strength, duration, quantity and route, signature and initials of person placing/receiving order, date order was placed/received. Random audits of drug record books on two identified home areas occurred for the past six months. Drugs that were ordered were missing signatures and dates when they arrived in the home or were missing the quantity. This was confirmed with the registered nursing staff, drug record books and audits completed by the pharmacy.

C) The licensee failed to ensure that the policy named "Medication administration rounds" was complied with. The policy directed staff to administer medications to a resident ensuring the resident swallows them, unless there are physicians' orders to leave medications at bedside. During the observation of a noon medication pass during this inspection on an identified home area, the registered nursing staff administered medications to two residents at the same time. The two resident medication cups were carried together from the medication cart to the residents' dining table and both were administered to two separate residents. The same registered nursing staff took medications to residents tables and left them in front of the residents without ensuring the resident swallowed them. This was confirmed by observation. On March 13, 2015 during the initial tour of the home, two residents in identified rooms, were observed with pill cups which had pills in them, sitting on their bedside tables. The residents were unaware the pills were there or who left them. One resident identified they thought they were for diarrhea, but wasn't sure and didn't want to take them. The same policy directed staff to

ensure medications are not left on top of an unattended cart. During the same medication observation period, a bottle of liquid medication was left on top of the cart while the cart was stationed at the entrance to the dining room. Several residents passed the medication cart while entering the dining room and the cart remained unattended and the medication was accessible and unsupervised.

D. The licensee has failed to ensure that the policy named "Narcotics and controlled substances" was complied with. On an identified date in December 2014 registered nursing staff did not count the narcotic drug supply at the beginning of the shift and complete the narcotic count sheet. On the identified date at 1400 hours, the count was completed and it was identified there were six narcotic medications missing. This was confirmed by documentation and the Assistant Director of Care.

E. The licensee has failed to ensure that the policy named [Skin and Wound Care Management Program Nur-POL/11] was complied with. The policy directed staff to document treatments and weekly wound reassessments on the treatment sheets.
i. The treatment sheets for resident #333 were missing signatures for treatment due on identified dates in December 2014. Also a catheter bag was to be changed weekly and it had not been signed for the period of December 20-31, 2014.
ii. The treatment sheets for resident #321 were missing signatures for treatment due on March 3, 11, 15, 16, 2014.
iii. The treatment sheets for resident #008 were missing signatures for treatment due on identified dates in July 2014. The treatment sheet was missing signatures for weekly skin assessments due on identified dates in July 2014, August 2014, September 2014, October 2014, November 2014 and December 2014.
iv. The treatment sheet for resident #008 was missing signatures for weekly skin assessments due on an identified date in February 2015.
The missing signatures were confirmed from the documentation. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee did not ensure that staff at the home complied with the home's policy and procedure related to documentation [Documentation Guidelines -RCC-POL/1, last revised October 23, 2013].

The home's policy related to documentation indicated that "Records must be clear, concise, accurate, true and an honest account of what happened".
On an identified date during this inspection, during an interview with a PSW staff, they indicated that they were not able to provide the bath for resident #405 that day, because they did not have time. During a review of the resident's Nursing Flow Record, it was

noted, according to the legend, that the resident refused their bath on March 26, 2015. The documentation on the Flow record was incorrect as staff confirmed that the resident was not offered a bath that day.
During a review of the Nursing Flow Sheets for eight residents on an identified home area, the documentation on their Nursing Flow Sheets indicated that of the 50 scheduled baths for these residents between March 1 and 23, 2015, some baths were performed, some baths were refused and some had no documentation at all related to whether the bath was even offered to the resident.
The documentation on the flow records related to bathing was not complete and some of the documentation was found to be unclear and not a true and honest account of what happened. [s. 8. (1) (b)]

3. The licensee has failed to ensure that the policy and procedure for transcribing physicians orders was complied with.

The home's policy [Department Standard Manual, Transcribing Physicians Orders(Nursing Standard], last revised July 2013, indicated that when there was a change in direction, place a sticker on the strip packages containing that dose. Fax the order to the pharmacy. Note on the medication administration record, where current order present, "Change in Direction" in red and with date and initial, make a vertical line through the last day given, cross out the order in the left margin and rewrite the new order in a blank box.
During a review of resident #104's clinical record, it was noted that upon admission, the resident was ordered a medication at 0800 hours and when the resident was at home the resident was taking this medication at 1700 hours. The family informed the home that the resident was receiving this medication at the incorrect time during an observation of a medication pass. The home did not follow their policy for transcribing physician orders and change in direction which resulted in inconsistent medication administration to the resident and this was confirmed with the ADOC. [s. 8. (1) (b)]

4. The licensee did not ensure that staff followed the home's policy related to Falls Prevention and Management [NUR-POL/3 - dated as last reviewed October 15, 2014]

The home's policy related to Falls Prevention and Management directed staff to; determine the resident's level of risk as low or high, communicate these findings to the therapy department and Falls Prevention team; Monitor and evaluate the care plan at least quarterly in collaboration with the interdisciplinary team; If the interventions have not been effective in reducing falls, initiate alternative approaches and update as necessary; Monitor, evaluate and document resident progress and outcomes;

Interdisciplinary team to conduct an interdisciplinary care conference to determine the possible cause of the falls and develop changes to prevent recurrence based on a quality improvement methodology of Plan, Do, Study, Act.
Resident #013 sustained 12 falls during a five month time period with the last fall resulting in an injury. A review of the health record for the resident and a review of the meeting notes for the "Falls and Restraint Committee" meetings confirmed that resident #013's falls risk was not reviewed during these meetings. The interventions on the resident's care plan were not reviewed and evaluated when ineffective and alternate approaches initiated as per the policy. There was no evidence to suggest that an interdisciplinary team conference was held to determine the possible causes of the falls nor was there development of changes to prevent recurrence. [s. 8. (1) (b)]

5. The licensee has failed to ensure the documentation policy was complied with.

The home's policy "Documentation Guidelines" [RRC-POL/1; last revised October 23, 2013] indicated that each discipline in the home is responsible for following documentation guidelines, and that records must be clear, concise, accurate, true and an honest account of what occurred.
i. Observation of an identified home area on March 19 and 20, 2015 revealed that morning nourishment pass was not completed; however, review of the unit's Food and Fluid Records on an identified date in March 2015 revealed that a staff member had documented that the residents received fluids on March 19 and 20, 2015.
ii. Resident #201 was observed on March 19, 2015 in bed at 0800 hours. The resident was brought into the main lounge at 1020 hours. The resident was observed with only a drink until 1145 hours. Interview with two PSW's and an RPN confirmed the resident was offered a breakfast tray but they refused. Review of the resident's Food and Fluid Record on an identified date in March 2015 revealed that a staff member had documented that the resident consumed 50 per cent of their breakfast meal and drank two servings of fluids. [s. 8. (1) (b)]

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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee did not ensure that residents who used bed rails were assessed in accordance with evidence based practices to minimize risk to the resident, taking into consideration all potential zones of entrapment. Evidence based practices have been identified by the Ministry of Health and Long Term Care as those developed by Health Canada related to bed safety.

According to the licensee's registered staff, residents were not assessed using guidelines titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and endorsed by Health Canada). According to the guidance document, residents need to be evaluated while sleeping in bed over a period of time by an interdisciplinary team to determine if the bed rail(s) are a safe alternative for the resident after trialling other options. Factors such as the status of the bed system, residents' sleep patterns, habits, medication use, cognition, communication, risk of falling and many other considerations need to be considered.

No template, decision tree or questionnaire had been developed to ensure a consistent and complete assessment of each resident which would also have included input from personal support workers and physiotherapists. The assessment that was completed included the resident's bed system, and included whether the resident's bed passed or failed all four zones of entrapment. The Physiotherapist completed their own individual assessment which included whether the resident could use the rail for repositioning, bed mobility or transfers, but did not include any safety considerations with respect to zones of entrapment and other hazards.

Compliance Order #014 was previously issued for an inspection (2014-188168-0014) conducted between May 21 and June 3, 2014 and Order #004 issued for an inspection (2014-189120-0079) conducted on December 2-4, 2014 for non-compliance regarding resident assessments to minimize risks to the resident where bed rails are used. The conditions laid out in the previous Order were not fully met during this inspection [s. 15. (1) (a)]

2. The licensee did not ensure that where bed rails were used that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Five residents were observed to be lying in a bed with one or both bed rails elevated on April 14, 2015. Confirmation was made with management staff that all five beds failed one or more entrapment zones. None of the beds were observed to be equipped with any type of mitigating entrapment zone accessory either on the rail or between the mattress and elevated bed rail. The Active Care Plans Report for the five residents was reviewed with the Director of Care and no report contained any information about the bed rail risks, why they were being used or that the resident required any accessories to mitigate the entrapment zone risks.

A small number of beds were seen with at least one bed rail elevated while residents were out of bed. The beds observed were of the style and model that did not pass entrapment zones 2 or 3. No bed accessories were noted to be employed on any of the elevated bed rails to minimize entrapment zone risks. [s. 15. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure every resident was offered a between-meal beverage in the morning.

i. On March 19, 2015, at 1140 hours, morning nourishments had not yet been offered to residents in the Pine Grove home area. A PSW stated that they did not have time to get to the nourishment cart because there were only two staff on the unit and they were still completing morning care. Interviews with registered staff and two PSWs confirmed that not all residents were offered a beverage in the morning.
ii. On March 20, 2015, at 1220 hours, morning nourishments had not yet been offered to residents again in the Pine Grove home area.
iii. Review of the unit's Food and Fluid Records revealed that between March 13–18, 2015, almost all residents had zero fluids at morning nourishment pass, with the exception of only five residents who had something to drink documented once within that six day period.
iv. Review of the unit's Food and Fluid Records on March 23, 2015, revealed that staff had documented that the residents received fluids in the morning on March 19 and 20, 2015; however, observation revealed they did not. [s. 71. (3) (b)]

2. The licensee has failed to ensure that all planned menu items were offered and available.

A) The home's menu for March 25, 2015, indicated vanilla donut holes were to be served at afternoon nourishment pass on all units. Observation by Inspector #506 on March 25, 2015, on an identified home area confirmed that vanilla donut holes were not offered to the residents.

B) The home's menu for March 25, 2015, indicated cheese and crackers were to be served at evening nourishment pass on all units. Observation of the evening nourishment pass on an identified home area on March 25, 2015, confirmed that cheese and crackers were not offered to the residents. This was confirmed by the registered staff.

C) The home's menu for March 26, 2015, indicated ice cream cups were to be served at afternoon nourishment pass on all units. Observation of the afternoon nourishment pass on an identified home area home area on March 26, 2015, confirmed that ice cream cups were not offered to the residents. Inspection of the unit's servery and back kitchen confirmed ice cream cups were not available on the unit. [s. 71. (4)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods; O. Reg. 79/10, s. 72 (2).
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable; O. Reg. 79/10, s. 72 (2).
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).
(e) menu substitutions that are comparable to the planned menu; O. Reg. 79/10, s. 72 (2).
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. A) The licensee has failed to ensure the home's food production system provided for standardized recipes for all menu items.

On March 17, 2015, food production was observed in the kitchen and the following were noted:

Recipes were not always available or followed.
i. Interview with the cook confirmed the cream of mushroom soup lunch came from a can; however, the recipe directed staff to make it from scratch.
ii. There were no recipes in the binder that the cooks used in the kitchen for the minced and pureed chicken burgers.
iii. There was no recipe for the lamb stew. The FSM confirmed that the beef stew recipe was being used; however, the substitution of lamb was not made on the recipe.
iv. The recipe for beef vegetable soup included potatoes; however, the cook confirmed potatoes were not used.
v. The recipe for pureed chicken salad sandwich instructed the cooks to puree the sandwich filling with bread and milk in the food processor. The cooks confirmed the chicken salad is served separately from the bread pudding. Observation during meal service confirmed this.
vi. The recipe for the tossed salad included lettuce, cucumber, tomato, green pepper, onion, carrot and radish; however, observation confirmed only lettuce, tomato and cucumber were used.
vii. The recipe for pureed white fish instructed the cooks to dot mayonnaise on the fish and sprinkle with lemon juice, garlic powder and black pepper before baking in the oven. Observation confirmed the fish went into the oven without any added ingredients.
viii. The recipe for the pureed turkey sandwiches instructed the cooks to mix the meat in the food processor with bread and milk. The cook confirmed they mix the turkey with mayonnaise and a touch of water.
ix. The recipe for pureed tossed salad instructed the kitchen staff to place one half cup of the prepared salad with one tablespoon of 'Thick It" per serving into the food processor, and to scale up based on the number of servings. The dietary worker was observed pouring the thickener straight from the can into the food processor without following measurements.
x. Review of the cooks' recipe binder revealed there were no breakfast recipes. Interview with the cooks confirmed they do not have any breakfast recipes as they just follow the same procedures every day. The FSM confirmed the breakfast recipes were accidentally placed into a separate binder; however, the cooks were not aware and confirmed they were not following any recipes for breakfast meals.

B) The licensee has failed to ensure the home's food and production system provided for documentation on the production sheet of any menu substitutions.

On March 17, 2015, food production was observed in the kitchen and the following were noted:

i. The original menu for Tuesday's dinner was substituted for lamb stew with tea biscuits and cupcakes due to St. Patrick's Day; however, these items were not documented on the cook's production sheets. When asked how the cook knew how much to make, they replied that they are just making the amount they would make for an alternate stew.
ii. The home substituted caramel cake for Wednesday's dinner as the planned dessert was unavailable; however, this was not documented on the cook's production sheets. [s. 72. (2)]

2. The licensee has failed to ensure that all food and fluids in the food production system were prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality.

Portion sizes indicated on the production sheet were not always followed, resulting in the residents being not served the correct portion sizes.
Lunch meal service was observed on March 18, 2015, in an identified dining room and the following was observed:
i. A #16 scoop was indicated for minced and puree chicken burger on a bun; however, a smaller #10 scoop was used instead, resulting in a smaller serving size for the residents and less nutritive value.
ii. A #8 scoop was indicated for pudding; however, a smaller #10 scoop was used. As a result, the dining room ran out of regular pudding and the last table served was given applesauce and not given the choice of pudding.

Lunch meal service was observed on March 20, 2015, in an identified dining room and the following was observed:
i. A #20 scoop was indicated for minced and pureed ham and swiss sandwiches; however, a smaller #10 scoop was used instead, resulting in a smaller service size for the residents and less nutritive value.
ii. A #8 scoop was indicated for stewed apples and for ice cream; however, #10 scoops were used.
iii. A #6 scoop was indicated for the regular and pureed pizza soufflé; however, a #10 scoop was used. [s. 72. (3) (a)]

Additional Required Actions:

CO # - 005, 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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 all residents were provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

A) A review of the clinical records for resident #203 identified that they had been assessed as a high nutritional risk by the RD due to a very low Body Mass Index, a history of reduced intake of foods and fluids and a potential for choking. The plan of care directed staff to provide supervision at meals, specifying oversight and encouragement, as well as to ensure staff are close by the resident's room to listen for any signs of choking and to check on the resident every five to 10 minutes. On an identified date in March 2015, at 1208 hours, the resident was observed eating in bed, and the staff did not pass by or enter the resident's room to observe the resident by 1220 hours when the resident finished eating. This lack of supervision and encouragement, as per the plan of care, did not allow the resident to eat as safely as possible.

B) Resident #217's documented plan of care indicated they require full assistance with eating. During lunch service on an identified date in March 2015, the resident was observed being fed their entrée by a PSW, who then went on to feed another resident. Resident #217 was served applesauce for dessert and attempted to eat it independently. The PSW came over to intervene and gave the resident two spoonfuls of the applesauce, then placed it aside and said they would return to feed the resident the rest when they were able. The resident did not receive the rest of their dessert. [s. 73. (1) 9.]

2. The licensee has failed to ensure proper feeding techniques were used to assist residents with eating at meals.

During lunch meal observation on March 18, 2015, in an identified dining room, a staff member was observed feeding a resident while standing up beside the resident.
i. After the inspector inquired about this, the staff member stated that because the resident's wheelchair was higher than most. The resident often displayed a behaviour while eating, they preferred to stand related to this behaviour. The staff member also stated that their back hurt when they sat to feed the resident. The inspector suggested the staff member use the adjustable chair available in the dining room to raise themselves up; however, the staff member said they could not as it was in use by another staff member.
ii. Interview with the RD confirmed this was an unsafe feeding practice due to an increased risk of choking from head extension. The RD also confirmed that dignity is not maintained when a person is standing over a resident to feed them. [s. 73. (1) 10.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian.

A) Resident #212's Treatment Administration Sheets (TAR) and progress notes revealed that they had an area of altered skin integrity. Review of the resident's plan of care and interview with the RD on March 26, 2015, confirmed they had received a referral for the wound on March 4, 2015; however, had yet to assess the resident regarding the wound.

B) Resident #211's TAR and wound care progress notes (PN-WC) revealed that they had an area of altered skin integrity on an identified date in February 2015, and another pressure area on an identified area in March 2015. Review of the resident's plan of care and interview with the RD on March 26, 2015 confirmed they were not sent a referral for the wound until March 24, 2015; however, the RD stated that each time a PC-WN is created, an e-mail referral is automatically sent to the RDs. The RD confirmed they had not assessed the resident regarding the wounds. [s. 50. (2) (b) (iii)]

2. The licensee has failed to ensure that resident #334, #321, #009 and #008, who were all exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff,

if clinically indicated.

A) On an identified date in July 2014, resident #334 developed a stage two wound. The wound was not reassessed from July 21 to September 15, 2014, and from November 11 to December 1, 2014. On October 13, 2014, there was a treatment change and the wound was not reassessed from November 11 to December 1, 2014, from December 9 to December 30, 2014, from January 6 to January 27, 2015, and from January 27 to March 3, 2015. The wound was then reassessed as a healing stage one wound.

B) On an identified date in August 2014, resident #321 developed a stage one wound. On an identified date in August 2014, the resident developed a second wound and they both deteriorated to stage four wounds. The wounds were not reassessed from September 30 to October 21, 2014, and from November 27 to December 16, 2014. On an identified date in December 2014, the resident developed a third wound. The wounds were not reassessed from January 15 to February 7, 2015. The wounds were then reassessed as healing stage two wounds.

c) On an identified date in June 2014, resident #009 developed a stage four wound. The wound was not reassessed from July 24 to August 14, 2014. Note: the resident did refuse to have a reassessment on one occasion. The wound was not reassessed from August 21 to September 18, 2014, and was noted to have worsened. The wound was not reassessed from November 13 to December 2, 2014, and from January 13 to February 5, 2015. The wounds were then reassessed as healing stage three wounds.

D) On an identified date in July 2014, resident #008 developed a stage two wound. The wound was not reassessed from July 22 to August 18, 2014, from August 27 to September 23, 2014, and from November 4 to December 17, 2014. The wound deteriorated from a stage one wound to a stage three wound. The wound was not reassessed from December 30, 2014 to January 20, 2015, from January 27 to February 17, 2015, and from February 24 to March 17, 2015. The wounds were then reassessed as healing stage one wounds.

The clinical documentation identified in the progress notes and on the treatment sheets and interviews with the registered nursing staff, Assistant Director of Care/wound nurse and the Director of Care confirmed the weekly reassessments of all three residents were not completed. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 has failed to ensure that staff collaborated in the development and implementation of every resident's plan of care so that the different aspects of care were integrated and consistent with and complement each other.

A) Interview with the RD on March 18, 2015, confirmed that they complete the Nutrition section of each resident's plan of care, but do not complete the Activities of Daily Living (ADL) section related to eating assistance as that is done by registered nursing staff. Under the Nutrition section of resident #201's documented plan of care, it indicated that the resident was to receive a soft texture diet with minced solid meats/minced sandwich fillings; however, under the ADL section, it indicated that the resident was to receive a regular textured diet.

B) Under the Nutrition section of resident #002's documented plan of care, which was completed by the RD, it indicated that staff were to provide total feeding assistance to the resident; however, under the ADL section, which was completed by registered nursing staff, it indicated that the resident required setup help only for meals. [s. 6. (4) (b)]

2. The licensee has failed to ensure that all residents were provided care as per their plans of care.

A) Resident #202's documented plan of care indicated the resident was to receive a muffin at morning nourishment pass. Interview with the dietary aide responsible for preparing nourishment carts for the home confirmed the resident was to receive a muffin in the morning as evidenced by the observation of the labeled snack ticket. On March 19 and 20, 2015, observation revealed morning nourishment pass was not completed on an identified home area, and the resident's Food and Fluid Intake Form confirmed the resident did not receive their labeled snack as per their plan of care.

B) Resident #204's documented plan of care indicated that the resident was at high nutritional risk and was to receive supervision at meals, specifically oversight, cueing or encouragement. On an identified date in March 2015, the resident was observed from 1127 – 1137 hours eating their lunch in their room alone. The resident finished eating, having only consumed 25 per cent of their meal, as evidenced by observation and review of the Food and Fluid Intake Form.

C) Resident #208's documented plan of care and diet list indicated that the resident was not to receive any white bread, rice or pasta. During lunch on March 23, 2015, the resident was served a tuna salad sandwich on white bread.

D) According to the home's diet list for an identified home area, residents #204, #209 and #210 were to receive small portions for meals. Observation during lunch service on March 23, 2015, the residents all received regular portions.

E) Resident #206's diet list indicated that the resident was to receive a glass of milk at each meal. Observation of lunch meal service on March 26, 2015, confirmed the resident received juice and tea, but did not receive milk at lunch.

F) Resident #207's diet list indicated that the resident was to receive small portions at meals and to be offered seconds. Observation of lunch meal service on March 26, 2015, confirmed the resident received a regular portion and was not offered seconds.

G) Resident #217's plan of care and diet list indicated the resident was to receive a banana at breakfast. Observation of breakfast meal service on March 31, 2015, confirmed the resident was not offered and did not receive a banana.(586) [s. 6. (7)]

3. The licensee failed to ensure that the provision of care set out in the plan of care was documented.

A) The plan of care for Resident #501 directed staff to apply a topical medication twice daily to an identified area. The treatment sheets for resident #501 revealed the topical medication was not documented as provided a number of times in January 2015, February 2015, and March 2015.

B) The plan of care for Resident #502 directed staff to apply a topical medication twice daily to an identified area. The treatment sheets for resident #502 revealed the topical medication was not documented as provided a number of times in January 2015, February 2015, and March 2015.

C) The plan of care for Resident #503 directed staff to apply a topical medication twice daily to identified areas. The treatment sheets for resident #503 revealed the topical medication was not documented as provided a number of times in January 2015, February 2015, and March 2015.

The documentation confirmed the lack of documented treatments for all three residents. [s. 6. (9) 1.]

4. The licensee failed to ensure that the provision of care set out in the plan of care was documented.

A) A review of resident #104's Nursing Flow Record sheet for July 22-29, 2014, indicated

that on a number of occasions the resident did not receive mouth care.
i. A review of the bath assignment for resident #104 showed the resident should have received two baths in an identified time frame in July 2014. The nursing flow sheet indicated that the resident did not receive a bath. There was no documentation in the progress notes to suggest the resident refused their bath on either occasion.
ii. A review of resident #104's Nursing Flow Record sheet during an identified one week time frame in July 2014, indicated the resident did not receive morning/bedtime care three times and was only shaved once during that time.
The ADOC confirmed that the documentation was not completed. [s. 6. (9) 1.]

5. The licensee did not ensure that staff documented the provision of care set out in the plan of care related to bathing.

B) During a review of the Nursing Flow Record sheets for residents #214, 216, 406, 407, 215, 408, 409 and 410, who resided on an identified home area, the documentation indicated that of the 50 scheduled baths for these residents that should have occurred during an identified time frame in 2015, some baths were performed, some were refused and some had no documentation at all related to whether the bath was even offered to the resident.
i. During an interview with the personal support worker staff, registered staff and the Director of Care, it was confirmed that when a resident refuses their scheduled bath, the PSW staff would be expected to notify the registered staff and the registered staff would then make a note in the resident's progress notes related to the resident's refusal.
ii. During a review of the progress notes for the eight identified residents, it was noted that there were no progress notes present on their health files related to the residents' refusals of their baths.
iii. It was also confirmed by registered and personal support worker staff that the baths are often not done because the staff don't have time but there was no documentation to confirm whether a bath was offered to these residents when documentation was absent on the Flow Sheets or the progress notes.
iv. Staff at the home did not document the provision of care for the eight residents reviewed related to bathing. [s. 6. (9) 1.]

6. A) The licensee did not ensure that the plan of care for resident #010 was updated when the resident's care needs changed.

i. Resident #010 was transferred to a private room on another unit on an identified date in 2014.

Prior to the move, the resident was noted to reside in a shared room with a shared bathroom. The resident was noted to health condition that prevented them from sharing a bathroom with another resident.
The document that the home referred to as the care plan for the resident indicated that the resident was to use their own sling and commode in the shower room that was dedicated for their use only. This care plan was in place prior to the resident's transfer to their new room.
ii. During a review of the care plan that was confirmed to be the most current and had been updated on March 3, 2015, it was noted that the direction to toilet the resident in the shower room was still present on their care plan.
iii. Staff interviewed confirmed that the resident was now toileted in their own bathroom.

B) The licensee has failed to ensure that resident #204's plan of care was revised when the resident's care needs changed.

i. Resident #204's documented plan of care indicated that the resident was at high nutritional risk and was to receive supervision at meals, specifically oversight, cueing or encouragement.
ii. On an identified date in March 2015, the resident was observed from 1327–1137 hours eating their lunch in their room alone. The resident finished eating, having only consumed 25 per cent of their meal, as evidenced by observation and review of the Food and Fluid Intake Form.
iii. A progress note two weeks later, documented a conversation between the resident and an RN regarding a concern the resident had. The note indicated that there were times when the resident felt they needed to have some assistance to feed themselves. The resident indicated that they were concerned that they wouldn't be fed.
iv. The progress note also indicated that the resident should be asked if they need assistance when dropping off their tray. PSW staff, who deliver the meal trays to the residents, do not have access to progress notes as confirmed by PSW's and registered staff. Review of the document the home refers to as the care plan, which front line staff refer to for the provision of care, revealed that there was no mention of the resident's updated feeding assistance needs and no documentation on the unit to direct the staff related to this. The plan of care was not updated when the resident's care needs changed.(586) [s. 6. (10) (b)]

7. The licensee did not ensure that the plan of care related to falls for resident #013 was reviewed and revised when the care set out in their plan of care was not effective.

i. Resident #013 sustained 12 falls over approximately five months in 2014 with the last fall resulting in an injury.
ii. The Minimum Data Set (MDS) assessment completed during that time period, indicated that the resident had sustained one fall in the past 30 days and no falls in the past 180 days. This information was incorrect, as the resident actually sustained nine falls in the 180 days prior.
iii. The resident was determined to be a moderate risk for falls due to the information that was coded in the assessment.
iv. During a review of the document that the home referred to as the care plan for resident #013, it was noted that there had been no changes or new interventions initiated in the resident's care plan related to their falls risk during the identified time frame despite the 12 falls that the resident had experienced. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the the provision of care set out in the plan of care for residents is documented in their plans of care related to bathing, mouth care and provision of treatments, morning and bedtime care and shaving and to ensure that residents are reassessed and their plans of care reviewed and revised when the care set out in their plans of care is not effective., to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #009 was not neglected by the licensee or staff.

i. Resident #009 had morning care completed around 1000 hours on an identified home are where the resident resided at that time.
ii. At 1030 hours the same day, resident #009 was transferred to another home area, the registered staff from the unit where the resident previously resided gave a report to the registered staff that was working on the new unit.
iii. Resident #009 indicated to the inspector that the resident arranged to have care completed with the staff at 2100 hours and confirmed that they did not see staff at this time. The resident went to look for the staff at 2130 hours and could not find the staff.
iv. Registered staff went into the resident's room around 0010 hours to administer the resident their medication and the resident was still up in their chair.
v. Resident's family member arrived on the unit at 0030 and the resident was found in their wheel chair and the resident was noted to be saturated in urine. The resident expressed embarrassment. Documentation review confirmed that the resident had a pressure ulcer and at that time, the resident did not have a dressing on the identified area. The resident had recently received antibiotic treatment for an extended period of time related to infection.
vii. The resident did not receive wound care, positioning, toileting and grooming care on the identified evening shift.
viii. The home confirmed through a Critical Incident Report that was submitted to the Director on that the resident was neglected. [s. 3. (1) 3.]

2. The licensee has failed to ensure that Resident #341 was afforded privacy in treatment. On an identified date in 2015, at 1215 hours, resident #341 was sitting in the dining room eating lunch. The resident was sitting at a table with three other residents and the registered nursing staff approached them and completed a finger prick to determine a capillary blood glucose reading which involved the resident's blood and then the same registered nursing staff member lifted the residents clothing, and proceeded to administer an injection of insulin. The resident was asked how they felt about receiving the two treatments in the dining room and the resident replied they didn't like it. [s. 3. (1) 8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident has the right not to be neglected by the licensee or staff and to ensure that every resident is afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

WN #9: 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 did not ensure that the resident-staff communication and response system was available in every area accessible by residents.

Activation stations to alert staff that assistance was required were not located on any balcony or outdoor courtyard used by residents. [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 to ensure that the resident-staff communication and response system (activation stations) are available in all areas accessed by residents, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee did not ensure that each resident of the home was bathed, at a minimum, twice a week by the manner of their choice and more frequently as required, unless contraindicated by their medical condition.

i. During a review of the Nursing Flow Sheets for eight residents, who resided on an identified home area, the documentation on their Nursing Flow Sheets indicated that of the 50 baths for these residents scheduled during an identified time frame in 2015, some baths were performed, some were refused and some had no documentation at all related to whether the bath was even offered to the resident.
ii. During an interview with the personal support worker staff, registered staff and the Director of Care, it was confirmed that when a resident refuses their scheduled bath, the PSW would be expected to notify the registered staff and the registered staff would then make a note in the resident's progress notes related to the resident's refusal.
iii. It was noted during a review of the progress notes for the eight identified residents, that there were no progress notes present on their health files related to the residents' refusals of their baths.
iv. It was also confirmed by registered and personal support worker staff that the baths were often not done because the staff didn't have time. There was no evidence that when the baths are refused that attempts are made later to bath the residents.
v. A review of the documents that the home refers to as the care plans for the eight residents revealed that their care plans related to bathing did not indicate that the residents were refusing their baths. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home is bathed, at a minimum, twice a week by the manner of their choice and more frequently as required, unless contraindicated by their medical condition, to be implemented voluntarily.

WN #11: 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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee did not ensure that procedures were developed for cleaning of the home, specifically flooring, common area furnishings and medication carts.

A) During a tour of the home between April 14 and 16, 2015, furnishings were observed to be soiled in appearance in the common areas of Birch, Primrose Lane, Lilac Garden, Rose Garden, Heritage Trail, Cherry Lane, Willow Grove and Maple Grove home areas. Cushions and arm rests were surface stained and when lifted, accumulated debris was found around the supporting frame. The licensee did not have an established procedure for addressing when the furnishings would be cleaned, by whom and how. No schedule had been developed and housekeepers who were interviewed stated that it was up to each housekeeper when the furnishings would be cleaned.
B) Flooring material in common washrooms in each home area were observed to be black in appearance from ground in dirt. Some of the tub rooms were observed with imbedded paint chips in the flooring material and the perimeter of the rooms had a black appearance. Many medical room floors were also black in appearance.
C) Medical carts were observed to be dirty on the interior in the Trillium and Maple Grove home areas. The expectation according to the Director of Care was that registered staff clean them as needed but no specific cleaning routine or procedure was developed. No specific location was allocated for staff to adequately clean the plastic boxes. One employee stated that they had to use a sink in an activity room as the sink inside the medical room was not an ideal size. [s. 87. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed for cleaning of the home, specifically flooring, common area furnishings and medication carts., to be implemented voluntarily.

WN #12: 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 kept in a medication cart was kept secure and locked.

i. On March 10, 2015 at 1145, Inspectors # 167 and # 586 observed a medication cart left in the lounge area beside the nurses' station on an identified home area.
ii. It was noted that Inspector #167 was able to open a drawer in the medication cart containing resident medications without difficulty. There were no staff in sight of the medication cart at the time.
iii.The registered staff returned and when the open cart was brought to their attention, they indicated that they thought that they had locked the cart and were just providing a treatment to a resident down the hall.
iv. The registered staff immediately locked the medication 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 to ensure that drugs are stored in an area of the medication cart that is secure and locked, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The license has failed to ensure that all drugs were administered to resident #205 in accordance with the directions for use specified by the prescriber.

Resident #205's MAR indicated that, as per physician's orders, the resident was to receive a specific dose of insulin subcutaneously twice daily, as required, if their capillary blood glucose (CBG) was greater than 15. Review of the resident's capillary blood glucose record revealed that on four identified dates in March 2015, the resident's CBG was greater than 15; however, review of the MAR confirmed the resident did not receive the insulin as per physician's orders on those dates. There was no documentation in the progress notes to indicate why the resident did not receive the insulin as prescribed. [s. 131. (2)]

Additional Required Actions:

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

WN #14: 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. Staff did not implement the infection prevention and control program, specifically related to disinfection and cleaning processes and outbreak control.

According to the home's infection control designate (ICD), personal care articles such as nail clippers, brushes and deodorant products were not to be left in any tub or shower room after the resident was bathed or showered. Signage was observed to be posted in many tub rooms on April 14, 2015, reminding staff to return personal products to resident rooms. Secondly, the ICD confirmed that staff that used the tubs and tub lift seats to bathe residents were responsible for cleaning the seat fully (all sides) after each use (as per tub seat manufacturer's directions) using a disinfectant and a brush. Procedures were not implemented based on the following;

A) Primrose, Cherry Lane, Birch, Lilac Garden tub rooms and the Trillium Lane shower all had unlabeled deodorant roll on sticks stored on or in cabinets. The Birch tub room had two small nail clippers in a basket and the Lilac tub room had one small nail clipper and a used unlabeled hair brush in a drawer.
B) Disinfectant was not hooked up to the tub over a 3-day period in Heritage Trail and Cherry lane tub rooms. The tub lift seats in the Oak Grove, Birch, Willow Grove, Maple Grove and Tulip Garden tub rooms were not clean, with accumulated soap scum on the underside of the seats over a three day period. [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 to ensure that staff implement the infection prevention and control program, specifically related to disinfection and cleaning processes and outbreak control, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

The licensee did not ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with related to s.20(2)d, the duty under section 24 to make mandatory reports.

i. The home's policy [Abuse/Neglect of a Resident" (RSK-POL-9; last revised May 9, 2014] directed staff to immediately advise the DOC or ADOC of any suspected abuse of a resident.
ii. On an identified date in 2015, as per a progress note by the unit's RN, resident #204 expressed concern to PSW #1 about an incident that had occurred earlier that evening. The resident stated that at 2200 hours they rang the call bell and told PSW #2 they needed the bed pan to have a bowel movement, and the PSW responded by saying " your bowels don't need to move at this hour". The note also stated that when the resident reported this to PSW #1, they offered the bed pan at that time, but the resident stated that because they had held it in for so long, they no longer felt like they needed to go. PSW #1 reported this incident to the RN who documented the progress note.
iii. Interview with the RN on March 26, 2015, confirmed that the incident was not reported to the ADOC.
iv. Interview with the ADOC for the North wing on an identified date in March 2015, confirmed that they were not made aware of the incident. [s. 20. (1)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 s.44(7) whereby the licensee refused an applicant's admission to the home based on reasons that are not permitted within the legislation.

i. On November 2014, the home refused client #500's application for admission to the home. The letter indicated that the home was refusing the client for admission because the home did not have the resources to fully meet the client's needs given the home's current population. The home indicated that they had were concerned that this would have the potential to put the client or others at risk.
ii. In December 2014, a Long Term Care Homes Inspector spoke with the DOC at the home and advised that the letter was not compliant and requested additional information be provided. The DOC agreed to review the application again and to resubmit an updated letter. The letter was not received.
iii. During this inspection, the inspector followed up on this concern and indicated to the home that the information requested previously was never received. The DOC confirmed that this letter was not sent.
iv. The Hamilton Service Area Office (HSAO) Manager discussed the refusal with the DOC and requested additional information to justify the refusal for admission. The requested letter was dated March 26, 2015, but was not received at the HSAO until April 29, 2015. The March 2015 letter indicated that the home was refusing the client for admission because the home did not have the resources to fully meet the resident's needs given the resident population on their secure units at that time. The letter indicated that the home was concerned that this had the potential to put the client and others at risk. The home denied the client's application.
v. Insufficient resources was not an acceptable reason for refusal of the client's application. The letters provided did not provide a detailed reason for the refusal, including how the client's care needs could not be met with regards to nursing expertise or the physical environment of the home. [s. 44. (7)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 and subsection (1), a response was made within 10 days in writing of the licensee receiving the advice.

i. During a review of the Family Council minutes for 2014 and 2015, it was noted that there were a number of concerns brought forward by the members of the Council.
ii. It was noted that there was no response provided in writing until the minutes of the next meeting, usually one month later or longer and there were no responses provided at all to some of the concerns identified in the minutes.
iii.During a discussion with the DOC and the Admissions Coordinator, who completes the minutes for the Family Council meetings, they noted that discussions take place with the Family Council President informally but the responses are not provided in writing within 10 days of the identified concern.
iv. In the minutes for the November 2014, December 2014 and February 2015 meetings, concerns were identified related to food quality, food temperatures, staff shortages, wheelchair cleaning, lack of recreation programming, communication, the home's patient/problem resolution process and perceived lack of accountability, not enough staff to toilet residents, shift report taking too long resulting in long waits to receive care.
v. There were no written responses provided within 10 days related to these concerns.
vi. During an interview with the Residents' Council president, they were not aware of written responses being provided to the Council in writing within 10 days of the concern being identified. [s. 60. (2)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's nutrition care and hydration programs include a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter, and body mass index and height upon admission and annually thereafter.

A) The home did not ensure that resident's heights were taken annually as evidenced by review of the home's clinical records. This was confirmed by the registered staff and RD.

B) During Stage I of the RQI, a registered staff member indicated to Inspector #167 that the staff on an identified home area were not completing every resident's weight monthly. Review of the health records of the residents on the unit (excluding two residents who were admitted in March 2015) confirmed that 14 of the 23 residents had not had their weights taken or recorded in February 2015. A sign posted in the nursing station read "weights to be done first week of the month"; however, as of an identified date in March 2015, most March weights had yet to be completed. [s. 68. (2) (e)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee did not inform the Director immediately of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

The home suspected a respiratory outbreak, involving residents on the North Tower of the home, on March 2, 2015. The staff put outbreak control measures in place, notified the Public Health Unit who declared the outbreak on March 6, 2015. The home did not notify the Director of the outbreak until March 10, 2015, when ministry staff made an unannounced visit and did not submit a critical incident until March 10, 2013. The outbreak was not reported to the Director immediately as required. [s. 107. (1) 5.]

Issued on this 11th day of June, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARILYN TONE (167), BERNADETTE SUSNIK (120), JESSICA PALADINO (586), LESLEY EDWARDS (506), YVONNE WALTON (169)
Inspection No. / No de l'inspection :	2015_201167_0006
Log No. / Registre no:	H-002113-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 21, 2015
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH SYSTEM 56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7
LTC Home / Foyer de SLD :	ST JOSEPH'S VILLA, DUNDAS 56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	David Bakker

To ST. JOSEPH'S HEALTH SYSTEM, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

1. The licensee shall ensure that staff at the home comply with the home's policies and procedures related to medication administration, ordering and receiving medications, medication administration rounds, narcotic and controlled substances, documentation guidelines, transcription of physician's orders, skin and wound care management and falls prevention.
2. The licensee shall ensure that training is provided to all appropriate staff to ensure their understanding and responsibilities related to these policies.
3. The licensee shall ensure that audits are completed related to compliance with these policies and the results of those audits are acted upon if required.

Grounds / Motifs :

1. Previously issued as a VPC April 2013, April 2014, May 2014 and September 2014.

A) The licensee has failed to ensure that the policy named [Medication Administration Record (MAR)] was complied with.
The policy directed staff to document on the reverse side of the MAR including reason for giving the medication and the effectiveness of the PRN (when required) dose. Resident #333 received a narcotic pain medication nine times in February 2015 for pain. The effectiveness of the medication was not documented on the reverse side of the MAR eight out of nine times. The same resident received one dose of the same medication in December 2014 and three times in March 2015. The effectiveness of the medication was not documented

on the reverse side of the MAR sheet for both months. This was confirmed by the registered nursing staff and documentation.

B) The licensee failed to ensure that the policy named [Ordering and receiving medications from the pharmacy] was complied with.
The policy directed staff to record the following information for every drug order: resident's name, drug name, strength, duration, quantity and route, signature and initials of person placing/receiving order, date order was placed/received. Random audits of drug record books on identified home areas occurred for the past six months. Drugs that were ordered were missing signatures and dates when they arrived in the home or were missing the quantity. This was confirmed with the registered nursing staff, drug record books and audits completed by the pharmacy.

C) The licensee failed to ensure that the policy named [Medication administration rounds] was complied with. The policy directed staff to administer medications to a resident ensuring the resident swallows them, unless there are physicians' orders to leave medications at bedside. During the observation of the noon medication pass during this inspection, in an identified home area, it was noted that the registered nursing staff administered medications to two residents at the same time. The two resident medication cups were carried together from the medication cart to the resident's dining table and both were administered to two separate residents. The same registered nursing staff took medications to residents' tables and left them in front of the residents without ensuring the resident swallowed them. This was confirmed by observation. On March 13, 2015, two residents in an identified home area were observed with pill cups which had pills in them, sitting on their bedside tables. The residents were unaware the pills were there or who left them for them. One resident identified they thought they were for diarrhea, but wasn't sure and didn't want to take them. The same policy directed staff to ensure medications are not left on top of an unattended cart. During the same medication observation period, a bottle of liquid medication was left on top of the cart while the cart was stationed at the entrance to the dining room. Several residents passed the medication cart while entering the dining room and the cart remained unattended and the medication was accessible and unsupervised.

D. The licensee has failed to ensure that the policy named [Narcotics and controlled substances] was complied with. On an identified date in December 2014, registered nursing staff did not count the narcotic drug supply at the

beginning of the shift and complete the narcotic count sheet. On the same day at 1400 hours, the count was completed and it was identified there were six narcotic medications missing. This was confirmed by documentation and the Assistant Director of Care. [s. 8. (1) (a),s. 8. (1) (b)] (169)

2. The licensee did not ensure that staff at the home complied with the home's policy and procedure related to documentation [Documentation Guidelines - RCC-POL/1, last revised October 23, 2013]. The home's policy related to documentation indicated that "Records must be clear, concise, accurate, true and an honest account of what happened". On an identified day in March 2015, during an interview with a PSW staff, they indicated that they were not able to provide the bath for resident #405 that day, because they did not have time. During a review of the resident's Nursing Flow Record, it was noted, according to the legend, that the resident refused their bath on the identified day. The documentation on the Flow record was incorrect as staff confirmed that the resident was not offered a bath that day. During a review of the Nursing Flow Sheets for eight residents on the identified home area, the documentation on their Nursing Flow Sheets indicated that of the 50 scheduled baths for these residents during an identified time frame in 2015, some baths were performed, some baths were refused and some had no documentation at all related to whether the bath was even offered to the resident. The documentation on the flow records related to bathing was not complete and some of the documentation was found to be unclear and not a true and honest account of what happened. [s. 8. (1) (b)] (167)

3. The licensee has failed to ensure that the policy and procedure for transcribing physicians orders was complied with.
The home's policy [Department Standard Manual, Transcribing Physicians Orders/ Nursing Standard, last revised July 2013], indicated that when there was a change in direction, place a sticker on the strip packages containing that dose. Fax the order to the pharmacy. Note on the medication administration record, where current order present, "Change in Direction" in red and with date and initial, make a vertical line through the last day given, cross out the order in the left margin and rewrite the new order in a blank box.
During a review of resident #104's clinical record, it was noted that the resident, upon admission, was ordered a medication at 0800 hours and when the resident was at home, the resident was taking this medication at 1700 hours. The family informed the home that the resident was receiving this medication at the incorrect time during an observation of a medication pass. The home did not

follow their policy for transcribing physician orders and change in direction which resulted in inconsistent medication administration to the resident. This was confirmed with the ADOC. [s. 8. (1) (b)] (506)

4. The licensee did not ensure that staff followed the home's policy related to Falls Prevention and Management [NUR-POL/3 - dated as last reviewed October 15, 2014]
The home's policy related to Falls Prevention and Management directed staff to; determine the resident's level of risk as low or high, communicate these findings to the therapy department and Falls Prevention Team; Monitor and evaluate the care plan at least quarterly in collaboration with the interdisciplinary team; If the interventions have not been effective in reducing falls, initiate alternative approaches and update as necessary; Monitor, evaluate and document resident progress and outcomes; Interdisciplinary team to conduct an interdisciplinary care conference to determine the possible cause of the falls and develop changes to prevent recurrence based on a quality improvement methodology of Plan, Do, Study, Act.
Resident #013 sustained 12 falls over approximately a five month period with the last fall resulting in an injury. A review of the health record for the resident and a review of the meeting notes for the "Falls and Restraint Committee" meetings confirmed that resident #013's falls risk was not reviewed during these meetings. The interventions on the resident's care plan were not reviewed and evaluated when ineffective and alternate approaches initiated as per the policy. There was no evidence to suggest that an interdisciplinary team conference was held to determine the possible causes of the falls, nor was there development of changes to prevent recurrence. This was confirmed by the Resident Care Coordinator. [s. 8. (1) (b)] (167)

5. The licensee has failed to ensure the documentation policy was complied with.
The home's policy "Documentation Guidelines" [RRC-POL/1, last revised October 23, 2013] indicated that each discipline in the home was responsible for following documentation guidelines, and that records must be clear, concise, accurate, true and an honest account of what occurred.
i. Observation of an identified home area on March 19 and 20, 2015, revealed that morning nourishment pass was not completed; however, review of the unit's Food and Fluid Records on an identified date in March 2015, revealed that a staff member had documented that the residents received fluids on March 19 and 20, 2015.

ii. Resident #201 was observed on March 19, 2015 in bed at 0800 hours. The resident was brought into the main lounge at 1020 hours. The resident was observed with only one drink until 1145 hours. Interview with two PSWs and an RPN, confirmed the resident was offered a breakfast tray but they refused. Review of the resident's Food and Fluid Record on an identified date in March 2015, revealed that a staff member had documented that the resident consumed 50 per cent of their breakfast meal and drank two servings of fluids. [s. 8. (1) (b)] (586)

6. The licensee has failed to ensure that the policy named [Skin and Wound Care Management Program" Nur-POL/11] was complied with. The policy directed staff to document treatments and weekly wound reassessments on the treatment sheets.
i. The treatment sheets for resident #333 were missing signatures for treatment due on specific dates in December 2014. Also a catheter bag was to be changed weekly and it had not been signed for an identified period of time in 2014.
ii. The treatment sheets for resident #321 were missing signatures for treatment due on identified dates in March 2014.
iii. The treatment sheets for resident #008 were missing signatures for treatment due on identified dates in July 2014. The treatment sheet was missing signatures for weekly skin assessments due on identified dates in July, August, September, October, November, and December 2014.
iv. The treatment sheet for resident #008 was missing signatures for weekly skin assessments due on identified dates in February 2015.
The missing signatures were confirmed from the documentation. (169)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2015

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2014_189120_0079, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall complete the following:
1. Interventions to mitigate entrapment risk shall be implemented for those residents who use one or more bed rails where one or more entrapment zone(s) failed on their bed system and the interventions shall be specifically documented in their plan of care.
2. All residents who use a bed rail shall be assessed for bed rail use by employing the guidelines identified in the FDA document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".
3. All residents who use one or more bed rails shall be assessed using an interdisciplinary team approach which at a minimum shall include a Physiotherapist or Occupational Therapist, a personal support worker and a registered nurse.
4. The result of the assessment shall be documented in the residents' plan of care and the information regarding the resident's bed rail use (which side of bed, size of rail, how many rails and why) shall be clearly identified so that health care staff have clear direction.
5. Update the existing bed safety and rail use policy to incorporate the information found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".

Grounds / Motifs :

1. Compliance Order #014 was previously issued for an inspection (2014-188168-0014) conducted between May 21 and June 3, 2014 and Order #004 issued for an inspection (2014-189120-0079) conducted on December 2-4, 2014 for non-compliance regarding resident assessments to minimize risks to the resident where bed rails are used. The conditions laid out in the previous Order were not fully met during this inspection

The licensee did not ensure that residents who used bed rails were assessed in accordance with evidence based practices to minimize risk to the resident, taking into consideration all potential zones of entrapment. Evidence based practices have been identified by the Ministry of Health and Long Term Care as those developed by Health Canada related to bed safety.

According to the licensee's registered staff, residents were not assessed using guidelines titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings,

2003" (developed by the US Food and Drug Administration and endorsed by Health Canada). According to the guidance document, residents need to be evaluated while sleeping in bed over a period of time by an interdisciplinary team to determine if the bed rail(s) are a safe alternative for the resident after trialling other options. Factors such as the status of the bed system, residents' sleep patterns, habits, medication use, cognition, communication, risk of falling and many other considerations need to be considered.

No template, decision tree or questionnaire had been developed to ensure a consistent and complete assessment of each resident which would also have included input from personal support workers and physiotherapists. The assessment that was completed included the resident's bed system, and included whether the resident's bed passed or failed all four zones of entrapment. The Physiotherapist completed their own individual assessment which included whether the resident could use the rail for repositioning, bed mobility or transfers, but did not include any safety considerations with respect to zones of entrapment and other hazards.
(120)

2. The licensee did not ensure that where bed rails were used that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Five residents (330-1, S242-1, N-436, N-338 and N-239) were observed to be lying in a bed with one or both bed rails elevated on April 14, 2015. Confirmation was made with management staff that all five beds failed one or more entrapment zones. None of the beds were observed to be equipped with any type of mitigating entrapment zone accessory either on the rail or between the mattress and elevated bed rail. The Active Care Plans Report for the five residents was reviewed with the Director of Care and no report contained any information about the bed rail risks, why they were being used or that the resident required any accessories to mitigate the entrapment zone risks.

A small number of beds in identified home areas were seen with at least one bed rail elevated while residents were out of bed. The beds observed were of the style and model that did not pass entrapment zones 2 or 3. No bed accessories were noted to be employed on any of the elevated bed rails to minimize entrapment zone risks. (120)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 15, 2015

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant:
2014_240506_0012, CO #001;
2014_188168_0014, CO #007;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee shall ensure all residents on the Pine Grove home area are offered a between-meal beverage in the morning.

Grounds / Motifs :

1. Previously issued as a compliance order May 2013, May 2014 and June 2014.

The licensee has failed to ensure every resident was offered a between-meal beverage in the morning.

i. On March 19, 2015, at 1140 hours, morning nourishments had not yet been offered to residents in an identified home area. A PSW stated that they did not have time to get to the nourishment cart because there were only two staff on the unit and they were still completing morning care. Interview with registered staff and two PSW's confirmed that not all residents were offered a beverage in the morning.
ii. On March 20, 2015, at 1220 hours, morning nourishments had not yet been offered to residents again in the same home area.
iii. Review of the unit's Food and Fluid Records revealed that between March 13–18, 2015, almost all residents had zero fluids at morning nourishment pass, with the exception of five residents who had something to drink documented once within that six day period.
iv. Review of the unit's Food and Fluid Records on March 23, 2015, revealed that staff had documented that the residents received fluids in the morning on March 19 and 20, 2015; however, observation revealed they did not. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2015

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2014_240506_0012, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Order / Ordre :

The licensee shall ensure that all planned menu items are offered and available at snacks.

Grounds / Motifs :

1. Previously issued as a compliance order in June 2014.

The licensee has failed to ensure that all planned menu items were offered and available.

A) The home's menu for March 25, 2015, indicated vanilla donut holes were to be served at afternoon nourishment pass on all units. Observation by Inspector #506 on March 25, 2015, of an identified home area confirmed that vanilla donut holes were not offered to the residents.

B) The home's menu for March 25, 2015, indicated cheese and crackers were to be served at evening nourishment pass on all units. Observation of the evening nourishment pass on an identified home area on March 25, 2015, confirmed that cheese and crackers were not offered to the residents. This was confirmed by the registered staff.

C) The home's menu for March 26, 2015, indicated ice cream cups were to be served at afternoon nourishment pass on all units. Observation of the afternoon nourishment pass on an identified home area on March 26, 2015, confirmed that ice cream cups were not offered to the residents. Inspection of the unit's servery and back kitchen confirmed ice cream cups were not available on the unit. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2015

Order # / Ordre no : 005

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

Linked to Existing Order / Lien vers ordre existant: 2014_188168_0014, CO #008;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Order / Ordre :

The licensee shall ensure standardized recipes are available and followed for all menu items and that any menu substitutions are documented on the production sheets.

Grounds / Motifs :

1. Previously issued a a compliance order May 2013, October 2013 and June 2014.

A) The licensee has failed to ensure the home's food production system provided for standardized recipes for all menu items.

On March 17, 2015, food production was observed in the kitchen and the following were noted:
Recipes were not always available or followed.
i. Interview with the cook confirmed the cream of mushroom soup lunch came from a can; however, the recipe directed staff to make it from scratch.

ii. There were no recipes in the binder that the cooks used in the kitchen for the minced and pureed chicken burgers.
iii. There was no recipe for the lamb stew. The FSS confirmed that the beef stew recipe was being used; however, the substitution of lamb was not made on the recipe.
iv. The recipe for beef vegetable soup included potatoes; however, the cook confirmed potatoes were not used.
v. The recipe for pureed chicken salad sandwich instructed the cooks to puree the sandwich filling with bread and milk in the food processor. The cooks confirmed the chicken salad was served separately from the bread pudding. Observation during meal service confirmed this.
vi. The recipe for the tossed salad included lettuce, cucumber, tomato, green pepper, onion, carrot and radish; however, observation confirmed only lettuce, tomato and cucumber were used.
vii. The recipe for pureed white fish instructed the cooks to dot mayonnaise on the fish and sprinkle with lemon juice, garlic powder and black pepper before baking in the oven. Observation confirmed the fish went into the oven without any added ingredients.
viii. The recipe for the pureed turkey sandwiches instructed the cooks to mix the meat in the food processor with bread and milk. The cook confirmed they mix the turkey with mayonnaise and a touch of water.
ix. The recipe for pureed tossed salad instructed the kitchen staff to place ½ cup of the prepared salad with one tablespoon of Thick It per serving into the food processor, and to scale up based on the number of servings. The dietary worker was observed pouring the thickener straight from the can into the food processor without following measurements.
x. Review of the cooks' recipe binder revealed there were no breakfast recipes. Interview with the cooks confirmed they do not have any breakfast recipes as they just follow the same procedures every day. The FSM confirmed the breakfast recipes were accidentally placed into a separate binder; however, the cooks were not aware and confirmed they were not following any recipes for breakfast meals.

B) The licensee has failed to ensure the home's food and production system provided for documentation on the production sheet of any menu substitutions.

On March 17, 2015, food production was observed in the kitchen and the following were noted:
i. The original menu for Tuesday's dinner was substituted for lamb stew with tea

biscuits and cupcakes due to St. Patrick's Day; however, these items were not documented on the cook's production sheets. When asked how the cook knew how much to make, they replied that they are just making the amount they would make for an alternate stew.
ii. The home substituted caramel cake for Wednesday's dinner as the planned dessert was unavailable; however, this was not documented on the cook's production sheets. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 14, 2015

Order # / Ordre no : 006

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

Linked to Existing Order / Lien vers ordre existant: 2014_188168_0014, CO #009;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Order / Ordre :

The licensee shall ensure that all food and fluids in the production system are served using methods to preserve nutritive value, specifically ensuring correct scoop sizes are used to serve food during meal service.

Grounds / Motifs :

1. Previously issued as a compliance order May 2013, October 2013 and June 2014.

The licensee has failed to ensure that all food and fluids in the food production system were prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality.

Portion sizes indicated on the production sheet were not always followed, resulting in the residents being not served the correct portion sizes.
Lunch meal service was observed on March 18, 2015, in an identified home area dining room and the following was observed:
i. A #16 scoop was indicated for minced and puree chicken burger on a bun; however, a smaller #10 scoop was used instead, resulting in a smaller serving size for the residents and less nutritive value.
ii. A #8 scoop was indicated for pudding; however, a smaller #10 scoop was used. As a result, the dining room ran out of regular pudding and the last table served was given applesauce and not given the choice of pudding.

Lunch meal service was observed on March 20, 2015, in an identified home area dining room and the following was observed:
i. A #20 scoop was indicated for minced and pureed ham and swiss sandwiches; however, a smaller #10 scoop was used instead, resulting in a smaller serving size for the residents and less nutritive value.
ii. A #8 scoop was indicated for stewed apples and for ice cream; however, #10 scoops were used.
iii. A #6 scoop was indicated for the regular and pureed pizza soufflé; however, a #10 scoop was used. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2015

Order # / Ordre no : 007

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

Linked to Existing Order / Lien vers ordre existant: 2014_188168_0014, CO #011;

Pursuant to / Aux termes de :

O.Reg 79/10, 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:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
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.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall ensure that residents #203 and #217 are provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Grounds / Motifs :

1. Previously issued as a compliance order June 2014.

The licensee has failed to ensure all residents were provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

A) A review of the clinical records for resident #203 identified that they had been assessed as a high nutritional risk by the RD due to a very low Body Mass Index, a history of reduced intake of foods and fluids and a potential for choking. The plan of care directed staff to provide supervision at meals, specifying oversight and encouragement, as well as to ensure staff were close by the resident's room to listen for any signs of choking and to check on the resident every five to 10 minutes. On an identified date in March 2015, at 1208 hours, the resident was observed eating in bed, and the staff did not pass by or enter the resident's room to observe the resident by 1220 hours when the resident finished eating. This lack of supervision and encouragement, as per the plan of care, did not allow the resident to eat as safely as possible.

B) Resident #217's documented plan of care indicated they require full assistance with eating. During lunch service on an identified date during this inspection, the resident was observed being fed their entrée by a PSW, who then went on to feed another resident. Resident #217 was served applesauce for dessert and attempted to eat it independently. The PSW came over to intervene and gave the resident two spoonfuls of the applesauce, then placed it aside and said they would return to feed the resident the rest when they were able. The resident did not receive the rest of their dessert. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2015

Order # / Ordre no : 008

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

Linked to Existing Order / Lien vers ordre existant:
2013_188168_0016, CO #005;
2014_248214_0013, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(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;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall ensure that every resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, including but not limited to residents' #334, #321, #009 and #008.

Grounds / Motifs :

1. Previously issued as a compliance order June 2014

The licensee has failed to ensure that resident #334, #321, #009 and #008, who were all exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) On an identified date in July 2014, resident #334 developed a stage two wound. The wound was not reassessed from July 21 to September 15, 2014 and from November 11 to December 1, 2014. On October 13, 2014 there was a treatment change and the wound was not reassessed from November 11, 2014 to December 1, 2014, from December 9, 2014 to December 30, 2014, from January 6 to 27, 2015 and from January 27, 2015 to March 3, 2015. The wound was then reassessed as a healing stage one wound.

B) On an identified date in August 2014 resident #321 developed a stage one wound. On another identified date in August 2014, the resident developed a second wound and they both progressed to stage four wounds. The wounds were not reassessed from September 30 to October 21, 2014, and from November 27 to December 16, 2014. On an identified date in December 2014 the resident developed a third wound.. The wounds were not reassessed from January 15 to February 7, 2015. The wounds were then reassessed as healing stage two wounds.

c) On an identified date in June 2014, resident #009 developed a stage four wound. The wound was not reassessed from July 24 to August 14, 2014. Note: the resident did refuse to have a reassessment on one identified date during the time frame. The wound was not reassessed from August 21 to September 18, 2014 and was noted to have worsened. The wound was not reassessed from November 13 to December 2, 2014 and from January 13 to February 5, 2015. The wounds were then reassessed as healing stage three wounds.

D) On an identified date in July 2014, resident #008 developed a stage two

wound. The wound was not reassessed from July 22 to August 18, 2014, from August 27 to September 23, 2014, and from November 4 to December 17, 2014,. During the five weeks, the wound deteriorated. The wound was not reassessed from December 30 to January 20, 2015, from January 27 to February 17, 2015 and from February 24 to March 17, 2015, missing two weeks of reassessment. The wounds were then reassessed as healing stage one wounds.

The clinical documentation identified in the progress notes and on the treatment sheets and interviews with the registered nursing staff, Assistant Director of Care/wound nurse and the Director of Care confirmed the weekly reassessments of all three residents were not completed. (169)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 14, 2015

Order # / Ordre no : 009 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_188168_0014, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that residents #202, #204, #206, #207, #208, #209, #210 and #217 receive care as per their plans of care.

Grounds / Motifs :

1. s. 6 (7) Plan of care not provided as per the plan.

The licensee has failed to ensure that all residents were provided care as per their plans of care.

A) Resident #202's documented plan of care indicated the resident was to receive a muffin at morning nourishment pass. Interview with the dietary aide responsible for preparing nourishment carts for the home confirmed the resident was to receive a muffin in the morning as evidenced by the observation of the labeled snack ticket. On March 19 and 20, 2015, observation revealed morning nourishment pass was not completed on an identified home area, and the resident's Food and Fluid Intake Form confirmed the resident did not receive their labeled snack as per their plan of care.

B) Resident #204's documented plan of care indicated that the resident was at high nutritional risk and was to receive supervision at meals, specifically oversight, cueing or encouragement. On an identified date in March 2015, the resident was observed from 1127 – 1137 hours eating their lunch in their room alone. The resident finished eating, having only consumed 25 per cent of their meal, as evidenced by observation and review of the Food and Fluid Intake Form.

C) Resident #208's documented plan of care and diet list indicated that the resident was not to receive any white bread, rice or pasta. During lunch on March 23, 2015, the resident was served a tuna salad sandwich on white bread.

D) According to the home's diet list for an identified home area, residents #204, #209 and #210 were to receive small portions for meals. Observation during lunch service on March 23, 2015, the residents all received regular portions.

E) Resident #206's diet list indicated that the resident was to receive a glass of milk at each meal. Observation of lunch meal service on March 26, 2015, confirmed the resident received juice and tea, but did not receive milk at lunch.

F) Resident #207's diet list indicated that the resident was to receive small portions at meals and to be offered seconds. Observation of lunch meal service on March 26, 2015, confirmed the resident received a regular portion and was not offered seconds.

G) Resident #217's plan of care and diet list indicated the resident was to receive a banana at breakfast. Observation of breakfast meal service on March 31, 2015, confirmed the resident did not get offered or receive a banana. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 21st day of May, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MARILYN TONE

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