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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 26, 2019	2018_414110_0013	006810-18	Resident Quality Inspection

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Altamont Care Community
92 Island Road SCARBOROUGH ON M1C 2P5

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

DIANE BROWN (110), JENNIFER BATTEN (672), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 21, 22, 23, 24, 28, 28, 30, 31, 2018. September 3, 4, 5, 6, 7, 10, 2018.

During this inspection the following intakes were conducted concurrently:
Critical Incident Report (CIR) related to a fall with injury;
Complaint related to lack of proper skin care.

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of health records, staff training records, staffing schedules, staff employment records, home's investigation record, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with Executive Director, Assistant Directors of Care (ADOC), Environmental Services Manager (ESM), Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), RAI Coordinator, Physiotherapist (PT), Occupational Therapist (OT), Nursing Clerk, Receptionist, Residents, Substitute Decision Makers (SDM's), and Presidents of Residents' Council and Family Council.

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

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

11 WN(s)
7 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

This inspection protocol triggered during stage one of the RQI related to a family interview and concerns around the cleanliness of resident #002's room and the cleanliness of the Long Term Care home in general.

On August 29, 2018 at 1445hrs an initial observation of resident #002's room, was completed by inspector #110. Subsequent observations with the same findings were made on August 30, 2018 at 1319hrs and August 31, 2018 at 1100hrs with inspector #623.
The observations were noted as follows:

Identified room A
-Wall under sink, visible from residents bed was soiled with circular brown splatters markings ranging in size from a quarter to a dollar coin.
-Tile floor around head of bed and side table, had dark brownish-black build up irregular patches and appeared soiled. Inspector #110 was able to wipe clean with a wet paper towel.
-Wall/flooring joints (especially in corners) and flooring thresholds (transition piece from hall to resident's room and resident's room to bathroom) were soiled with thick dark brownish-black build up.
-Toilet base – light -brown staining was observed surrounding base of toilet (query rust or

stool). Floor in bathroom stained with dark irregular patches and fluid drips with the appearance of being unclean.
-Hallway wooden baseboard outside room 405 and running between rooms 403 and 407 were soiled with what appeared to be beige dried food and brown beverage spill markings.
Further hallway observations were made of Wing 4 and Wings 1-3 with the following observations:
-Flooring thresholds (transition piece from hall to resident rooms) were identified as soiled with dark brownish-black build up entering rooms 402, 404, 406, 405, 408, 410, 412, 414, 416, 419, 415 and 409.
-Wall air exchange vents between rooms 419-417 and 311-309 were observed with heavy amounts of visible grey dust and debris. The wall air exchange vent located across from The Rouge room near the reception, measuring approximately three feet wide above baseboard to chair rail was heavily soiled with thick dust and drip markings appearing like brown beverage spills . The area where the air exchange vent meets the baseboard was soiled with the appearance of brown beverage drips.

Wooden baseboards were soiled with dried food and beverages spill markings running throughout the home in identified areas.

The observations were noted as follows:
Wing #1
-Vent outside room 118 and between rooms 113-115 were observed with a heavy amount of visible grey dust and debris.
-Door hallway transitions to rooms 118, 114, 108, 103, 104, and 102 were identified as heavily soiled with dark brownish-black build up.
-Wooden baseboards between rooms 118-116, outside 113, between rooms 111-109, 114-112, 109-107, 110-112, 108-106, 106-104, 103-105 and between room 105 and the shower room entrance were soiled with dried food and beverages spill markings.

Wing #3
-Vent outside room 311 was observed with heavy amounts of visible grey dust and debris.
-Door- hallway transitions of rooms 318, 311, 316, 3015, 312, 303, 310, 308 were identified as soiled with dark brownish-black build up.
-Wooden baseboards between rooms 311-309, outside rooms 314, 314-312, 312-310 and 308-306 were soiled with dried food and beverages spill markings.

Wing #2
-Hallway wall outside the program room, measuring approximately eight feet in length from the baseboard up the wall to the chair rail had many areas of green substance dried to the wall. The tile in the same area measuring approximately 12 inches from the floor up the wall was soiled with scuffed marks the entire length appeared dirty with dark markings and stains. The wooded baseboard above the tile had beige and dark brown dried food and liquid spills.
-Vent outside room 204 and 220 was observed with heavy amounts of visible grey dust and debris.
-Doorway transitions into rooms 204, 206, 208, 210, 207, 212, 209 and 218 were identified as soiled with dark brownish-black build.
-Wooden baseboards outside room 201, between rooms 201-203, 202-204, 203-205, 204-206, 210-212, 205 to the entrance of the bath area; outside rooms 207, 220, 216, 215, between 211-213 and 213-215 were soiled with dried food and beverages spill markings.
On August 31, 2018 at 1115hrs a tour was conducted with the home's Executive Director who confirmed the areas where soiled and represented a build-up beyond a monthly deep cleaning.

On August 31, 2018 at 1237hrs an interview with held with the newly appointed Environmental Services Manager (ESM), who had been in the position for an identified period of time. The interview revealed that they were, at that time, unaware of the deep cleaning requirements of the housekeeping staff. A tour was conducted with the ESM to observe an identified resident room, floor transitions from hallway to resident rooms; rooms to bathrooms; vents, wooden baseboards and floor stains. The ESM confirmed that the areas had not been cleaned daily or deep cleaned as expected by staff and the cleanliness of the home "was not up to standard".

The deep cleaning of floor transitions and baseboards was observed to begin upon return to the home on September 3, 2018.
[s. 15. (2) (a)]

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. 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was 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 were implemented.

Resident #012 triggered through to stage two of the RQI, related to the presence of an area of altered skin integrity.

During a record review, Inspector #672 reviewed resident #012's progress notes, which revealed that an area of altered skin integrity was first noted on an identified date on resident #012's body. Inspector #672 then further reviewed resident #012's progress notes, which indicated that weeks later, resident #012 was observed with a second area of altered skin integrity, and a month later a third area was noted. No progress notes were observed to indicate that the resident had been assessed by a RD following the observations of any of resident #012's skin integrity concerns.

Inspector #672 then reviewed the licensee's internal policy entitled "Skin & Wound Care

Management Protocol"; policy number: VII-G-10.80.SSLI; current revision: April 2018, which indicated the following: "Registered staff will:
4) With a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds:
c. Refer resident to the Registered Dietitian and other interprofessional team members, as required."

The policy went on to state the following:

"The Registered Dietitian will:
1) Assess residents exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears, or wounds.
2) Change resident's plan of care as needed relating to nutrition and hydration.
3) Make referrals as appropriate for the resident to Physician/NP, including further blood work and vitamins/minerals needed.

During an interview on September 6, 2018, RN #128 indicated that staff would not always send a referral to the RD when altered skin integrity was observed, if the resident was already being followed by the RD, which was the belief in why a referral was not sent for resident #012.

During a telephone interview on September 14, 2018, ADOC #101 indicated being responsible for the skin and wound program in the home. ADOC #101 further indicated that the expectation in the home was that referrals should be sent to the RD immediately following confirmation that the resident had an area of altered skin integrity, so that the resident exhibiting altered skin integrity could be assessed by the RD. ADOC #101 further indicated being aware that sometimes if the resident was already receiving a nutrition intervention or was being followed by the RD for another reason outside of skin integrity concerns, some nurses would not send a referral related to an impaired skin integrity concern. ADOC #101 indicated that if the nurse made that judgement, they would be considered to be in non-compliance with the licensee's policies, and follow up with the nurse to remind them of the need for a referral to be sent, to ensure the RD was aware of the most updated information regarding the resident's skin integrity, to assist in ensuring that the resident received an RD assessment.

During an interview on September 6, 2018, the DOC indicated that an RD assessment was required for all residents exhibiting altered skin integrity.

During an interview on September 10, 2018, the RD indicated that a referral was not sent following the initial observation of resident #012's altered skin integrity nor the two subsequent areas of altered skin integrity and therefore assessments were not completed specific to the resident's skin integrity. The RD further indicated that even when a resident was already receiving a nutritional intervention or being followed by the RD for another reason, a referral was still required for any new observation of altered skin integrity, as a new assessment of the resident would be completed, and the nutritional plan of care would often be changed, in account of the resident's increased nutritional needs, in order to promote healing.

At the time of this inspection, September 10, 2018 resident #012 continued to exhibit areas of altered skin integrity.

The licensee failed to ensure that when resident #012 was first noted to exhibit altered skin integrity, that the resident was assessed by a Registered Dietitian. [s. 50. (2) (b) (iii)]

2. The licensee has failed to ensure that resident #012 was reassessed at least weekly by a member of the registered nursing staff when the resident was exhibiting altered skin integrity, which included pressure ulcers and skin tears.

Resident #012 triggered through to Stage two of the RQI, related to the presence of an area of altered skin integrity.

During the record review in Stage II of the RQI, resident #012's clinical health records indicated that resident #012 had an identified area of altered skin integrity, which had been present since an identified date, and a second identified area of altered skin integrity present since another identified date.

During an interview on September 4, 2018, the DOC indicated the expectation in the home was that every identified area of altered skin integrity should be assessed and documented on, on a weekly basis.

Inspector #672 reviewed resident #012's progress notes, which revealed that an area of altered skin integrity was first noted on an identified date. Inspector #672 then reviewed resident #012's progress notes, which indicated that on an identified date, resident #012 was observed to have a second area of altered skin integrity, and weeks later a third area. Inspector #672 then reviewed resident #012's skin and wound assessments between a two month period, which revealed three identified weeks whereby there was

no documentation to support that the resident's identified areas of altered skin integrity were assessed by the registered staff and no documentation to support that the resident's second and third areas of altered skin integrity was assessed weekly by the registered staff.

During an interview on September 6, 2018, RN #128 indicated that the expectation in the home was that a weekly skin assessment should be completed for any resident who was exhibiting altered skin integrity, and that the registered staff had received education regarding when and how to complete the weekly skin assessments.

During a telephone interview on September 14, 2018, ADOC #101 indicated being the lead for the skin and wound program in the home. ADOC #101 verified that the expectation in the home was that a weekly skin assessment should be completed for any resident who was exhibiting altered skin integrity.

The licensee failed to ensure that resident #012 was reassessed at least weekly by a member of the registered nursing staff when the resident was exhibiting altered skin integrity. [s. 50. (2) (b) (iv)]

3. Related to Log #003982-17.

A complaint was received by the Director on an identified date, from resident #015's Substitute Decision Maker (SDM), who alleged that resident #015 passed away as a result complications to an area of altered skin integrity, which had been acquired in the home. The complainant further indicated that the staff did a very poor job of managing and treating the area of altered skin integrity, which had led to a complication.

Resident #015 had identified areas of altered skin integrity.

During an interview on September 4, 2018, the DOC indicated the expectation in the home was that every identified area of altered skin integrity was to be assessed by the registered staff, and documented on a weekly basis, which included measurements of the identified areas.

Inspector #672 completed a record review for resident #015 related to their skin condition and requested past copies of all of the skin assessments.
For altered area of skin integrity identified as A, no weekly assessments were observed on 14 occasions over an eight month period. For altered area of skin integrity identified

as B, no weekly assessments were observed on eight occasions over a two month period.

During a telephone interview on September 14, 2018, ADOC #101 indicated being the lead for the skin and wound program in the home. ADOC #101 verified that the expectation in the home was that a weekly skin assessment should be completed for any resident who was exhibiting altered skin integrity.

The licensee failed to ensure that resident #015's identified areas of altered skin integrity were reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for each resident sets

out clear directions to staff and others who provided direct care to the residents.

Resident #002 triggered through to stage two of the Resident Quality Inspection (RQI) related to falls prevention.

During an interview on August 31, 2018, Physiotherapist (PT) #110 indicated that resident #002 required described assistance for transfers. PT #110 further indicated that the transfer status of each resident was communicated to staff through transfer logos being posted above the bed for each resident, along with being listed within the Kardex and the written plan of care. PT #110 indicated that it was their responsibility to post the transfer logos above each resident's bed in the home, and the logo should be signed and dated by the PT once it was posted. This information would then be communicated to the RPN, who would ensure that the written plans of care and Kardex for the resident were kept current.

Inspector #672 reviewed resident #002's current written plan of care which indicated the resident's level of transfer assistance. The Inspector then reviewed the "Support Actions" section of PCC, which created the Kardex for PSW staff to review. The Kardex stated the resident required a different level of transfer assistance. Inspector #672 then observed the transfer logo posted above resident #002's bed. The transfer logo identified an incorrect level of transfer assistance. Inspector #672 observed the transfer logos posted above the beds of residents #021 and #022. PT #110 verified that the logos currently hanging above the bed for residents #002 and #021 were not the correct level of transfer status for the resident.

Inspector #672 then reviewed the plan of care for resident #021. According to the logo above resident #021's bed, the resident required an identified transfer intervention. Inspector #672 reviewed the resident's current written plan of care, which indicated that the resident required a different intervention with transfers.

During an interview on August 31, 2018, Physiotherapist (PT) #110 indicated that resident #021 shared the resident transfer status, and revealed that the transfer logo above the bed and the written plan of care were not correct, regarding the transfer status of the resident.

During an interview on August 30, 2018, PSW #104 indicated that resident #002 required two staff members to assist during each transfer. PSW #104 further indicated that staff would review the Kardex, the written plan of care, and look for signs posted above the

resident's bed to provide direction to the staff regarding the resident's care needs, and when there was confusion between the areas, staff would go to the nurse to clarify.

During an interview on August 31, 2018, ADOC #102 indicated that the PSW staff should refer to the transfer logo above the resident's bed for the most up to date and current transfer status of the resident. ADOC #102 further indicated that the transfer logo above the resident's bed should contain the same directions as that listed within the resident's Kardex and written plan of care, and indicated that clear direction was not provided regarding the transfer status of residents #002 and #021.

The licensee failed to ensure that resident #002 and #021's plan of care set out clear directions to staff and others who provided direct care to the resident, specific to the resident's transfer status. [s. 6. (1) (c)]

2. Related to Log #008586-18:

A Critical Incident Report (CIR) was submitted to the Director on an identified date, related to a fall sustained by resident #014 on an identified date and time. According to the CIR, resident #014 was transferring independently and lost their balance, which resulted in a fall. Upon assessment, resident #014 was complaining of pain to an identified area, therefore was transferred to hospital for further assessment, where the resident was admitted with a significant change in status.

Inspector #672 reviewed resident #014's plan of care in place at the time of the fall. The written plan of care, indicated that resident #014 was at high risk for falls due to attempting to transfer independently. A review of the progress notes over an identified period revealed that the resident sustained two falls during that time period. Following the first fall, four interventions were included in the plan of care. Inspector #672 then reviewed resident #014's progress notes over the next two month period which indicated that resident #014 had sustained two more falls. Inspector then reviewed resident #014's current plan of care. The written plan of care no longer identified that resident #014 was at risk for falling, and no interventions were listed. The Kardex did not indicate that resident #014 was at risk for falls, but did list that an identified intervention was required when up in the wheelchair.

During an interview on August 28, 2018, ADOC #101 indicated that the home had recently transitioned to a new documentation system, which affected the way the plans of care were documented, as the written plan of care and Kardex were being pared down to

only one page. ADOC #101 further indicated that the new written plans of care would only contain interventions in place for the resident that were not listed within the licensee's internal policies, such as for falls prevention. ADOC #101 indicated that interventions listed within the falls prevention policy were expected to be in place for every resident considered to be at risk for falls, and that all staff had been educated on the falls prevention policy. ADOC #101 further indicated that a focus of falls would no longer appear in a resident's written plan of care, even for residents identified to be at high risk for falls, unless the resident had an individualized intervention which would show up under the "Support Actions" tab in Point Click Care (PCC), and it was the responsibility of the registered staff to inform the PSW staff during shift report of the residents who were at risk for falls.

During a telephone interview on September 14, 2018, ADOC #102 indicated that following the RQI conducted in the home, the directions provided from the corporate office regarding the new documentation system related to each resident's falls risk and interventions no longer being listed within the plan of care had been reviewed, and indicated that the direction had changed. ADOC #102 further indicated that moving forward, the resident specific falls risk and interventions would be listed within the plan of care, which would be added to the written plans of care for residents identified as being at risk for falls during the next routine quarterly RAI-MDS assessment.

The licensee failed to ensure that resident #014's plan of care set out clear directions to staff and others who provided direct care to the residents, related to the residents falls risk. [s. 6. (1) (c)]

3. Resident #012 triggered through to stage two of the RQI, related to the presence of an altered area of skin integrity.

During the record review in Stage II of the RQI, resident #012's clinical health records indicated that resident #012 had two areas of altered skin integrity.

Inspector #672 reviewed resident #012's electronic medication administration record (eMAR) and electronic treatment administration record (eTAR) for an identified month. During the review, it was revealed that there were two separate physician's orders related to the treatment for the same area of altered skin integrity. One of the orders stated directions related to an area of altered skin integrity in location A of the resident, and the other order stated directions related to an area of altered skin integrity in location B of the resident.

Inspector #672 then reviewed the progress notes and skin assessments for resident #012 in the same identified time period. The documentation indicated resident #012 had only one area of altered skin integrity not two as the orders implied.

During an interview on September 7, 2018, RN #128 indicated that they had assessed the resident's area of altered skin integrity in an identified month, at which time the resident had one area of altered skin integrity, and had only been aware of the resident having one area.

Upon review of the eMAR, Inspector #672 observed that both orders had been signed to indicate the treatments had been administered four times in an identified month.

Inspector #672 then reviewed the staffing schedule, and verified with the receptionist and DOC that RPN #132 had worked during some of the shifts, and RPN #133 had worked the shift on one of the shifts.

During a telephone interview on September 7, 2018, RPN #132 verified signing both orders to indicate the treatments had been administered. RPN #132 indicated that when the treatments had been completed for resident #012, the resident only had one area of altered skin integrity. RPN #132 further indicated that the directions listed under the physician's order for the area of altered skin integrity A had been followed, not the directions listed for the area of altered skin integrity B, and found that having two treatment orders for resident #012 listed on the eMAR had been very confusing. RPN #132 indicated that the expectation in the home, and from the College of Nurses of Ontario, was that nurses were not to document or sign for medications or treatments which had not been provided to the resident. RPN #132 indicated that instead of signing both orders to indicate they had been administered, the orders could have been clarified with the RN or the physician, and the incorrect order should have been removed from the resident's eMAR to prevent further confusion, but this was not done, due to time constraints.

During a telephone interview on September 7, 2018, RPN #133 verified signing both orders to indicate the treatments had been administered on an identified date. RPN #132 indicated that when the treatment had been completed for resident #012, there had only been one area of altered skin integrity and they had followed the directions listed under the physician's order for the wound altered skin integrity A. RPN #133 further indicated being very confused during resident #012's dressing change, due to having two different

physician's orders listed, when the resident only had one area of altered skin integrity. RPN #133 indicated that they did not stop to verify the order with the RN or physician prior to completing the treatment, although there had been an RN available, and that it was not part of their usual practice to sign an order if it was not completed and/or administered to the resident as per the directions. RPN #133 indicated that the expectation in the home, and from the College of Nurses of Ontario, was that nurses were not to document or sign for medications or treatments which had not been provided to the resident.

During an interview on September 7, 2018, the DOC reviewed the orders listed in resident #012's eMAR and eTAR in an identified month. The DOC indicated that after reading the physician's orders, they would have expected that resident #012 had two separate areas of altered skin integrity, based on how each of the areas were described in the physician's orders; along with the differences in where the altered area was documented to be located. The DOC indicated finding the physician's orders very confusing, and due to the fact that resident #012 had only one area of impaired skin integrity present in the identified month, clear directions had not been provided to the staff who were caring for resident #012. The DOC further indicated that the expectation in the home was that if the registered staff had questions surrounding an order, or if the order was ambiguous or unclear in any way, the nurse should contact the physician prior to carrying out the order, and then only sign the eMAR/eTAR for the order which had actually been completed. The DOC indicated that if there was a physician's order visible in the eMAR or eTAR which was incorrect or inaccurate, the expectation in the home was that the nurse should clarify the order, and then either correct or discontinue the order, as required, and that the internal processes had not been followed in this circumstance.

The licensee failed to ensure that resident #012's plan of care set out clear directions to staff and others who provided direct care to the resident, specific to the treatment of the resident's area of altered skin integrity. [s. 6. (1) (c)]

4. The licensee has failed to ensure the plan of care is based on an assessment of the resident and the resident's needs and preferences.

This inspection protocol triggered related to an interview with resident #007 during stage one of the RQI.

During the interview with resident #007, the resident revealed to Inspector #110 that they would like to go to bed at identified times.

A record review of the resident's written plan of care included documentation of an identified bedtime. The entry was documented on in an identified month of 2018, by the regular day shift RPN #115.

An interview with PSW #121, #137 and #138 all confirmed that the plan of care and kardex provided direction on when a resident would prefer to go to bed.

An interview with resident #007's regular afternoon PSW #121, revealed that resident #007 wanted to go to bed at a identified time, hours different than what was stated in the plan of care and shared knowledge of the resident's bedtime preference. An interview with the resident's regular afternoon RPN #129 revealed the same knowledge of the resident. RPN #129 confirmed that the care plan documentation of resident's preferred bedtime was incorrect.

An interview with the RAI Coordinator #124 revealed that during the quarterly review the register staff were to ask the resident, who was cognitively intact, their sleep preference and update the written plan of care accordingly.

An interview with RPN #115 who completed the care plan entry at the quarterly review confirmed that they had not asked the resident their preference prior to updating the resident's plan of care. [s. 6. (2)]

5. This inspection protocol triggered related to an interview with resident #007 during stage one of the RQI. As a result of non-compliance being identified the sample size was expanded by two additional residents including resident #010.

During an interview with resident #010 the resident revealed to Inspector #110 that they like to go to bed at an identified time and that staff do ask at night what time they would like to go to bed.

A record review of the resident's written plan of care and kardex included documentation identifying the resident's bedtime. This entry was documented on in an identified month of 2018, by RN #134.

An interview with the RAI Coordinator #124 revealed that during the quarterly review the register staff were to ask the resident who was cognitively intact their sleep preference and update the written plan of care accordingly.

A telephone interview was conducted with RN #134, who completed the resident's bedtime care plan entry at the quarterly review. The RN shared their observations of resident #010 in the evening including that the resident was at risk for falling. The RN further stated they had not consulted with the resident when they entered the resident's bedtime preference in the written plan of care. The RN acknowledged it was their mistake and the resident should have been involved in their identifying their bedtime preference in their plan of care. [s. 6. (2)]

6. The licensee failed to ensure that the plan of care for resident #002 was provided to the resident, as specified in the plan.

Resident #002 triggered through to Stage II of the RQI specific to Falls Prevention, and the resident had sustained a fall within the previous 30 days.

A review of the progress notes over an approximate two month period indicated that the resident sustained multiple falls during that time period. Inspector #672 then reviewed the current written plan of care, which indicated that resident #002 was at moderate risk for falls, and to have an intervention in place at all times, when up in the wheelchair. The written plan of care also indicated that resident #002 had an area of altered skin integrity, with a specific intervention in place.

During the inspection Inspector #110 observed resident #002 without the required falls prevention intervention in place. On six more occasions during the course of the inspection, resident #002 was observed by Inspector #672 also without the required falls prevention intervention in place.

On three occasions during the course of the inspection, resident #002 was observed by Inspector #672 without the interventions in place related to altered skin integrity.

During an interview on August 30, 2018, PSW #104 indicated that resident #002 was at high risk for falls, and interventions included a safety device was to be in place and for the resident to notify staff if attempting to self-transfer. PSW #104 further indicated that resident #002 no longer had an area of altered skin integrity, and no longer required the identified intervention. PSW #104 indicated that due to the resident remaining up in the afternoons and being at high risk for falls, the resident needed to be observed and identified a location where the resident was to be located for close observation of the resident by the staff.

During separate interviews on August 31, 2018, RPNs #106 and #109 indicated that resident #002 was at high risk for falls, and had a safety device in place, and the resident was to notify staff if attempting to self-transfer. Both staff members verified how the safety device needed to be applied. RPN #106 further indicated that this intervention had been in place for resident #002 for a period of time, and all staff were aware of the resident's need to have the safety device in place.

During an interview on September 10, 2018, ADOC #102 indicated that resident #002 was known to frequently remove the safety device, therefore staff should check the periodically throughout the shift, to ensure the device was in place.

The licensee failed to ensure that the plan of care for resident #002 was provided to the resident, as specified in the plan, by not ensuring that the safety device was in place at all times and providing the intervention related to the resident's altered skin integrity. [s. 6. (7)]

7. Related to Log #008586-18:

A CIR, was submitted to the Director on an identified date, related to a fall sustained by resident #014. According to the CIR, resident #014 was transferring independently and lost their balance, which resulted in the fall. Upon assessment, resident #014 was complaining of pain therefore was transferred to hospital for further assessment, where the resident was admitted with a significant change in status.

Inspector #672 reviewed resident #014's plan of care in place at the time of the fall. The written plan of care indicated that resident #014 was at high risk for falls due to attempting to transfer independently.

A review of the progress notes over an identified two month period revealed that the resident sustained two falls during that time. Following the second fall interventions were included in the plan of care were put in place. Inspector #672 then observed resident #014's progress notes for another later two month period and observed that resident #014 had sustained two more falls during that time.

Inspector #672 observed resident #014 on three occasions. During each observation, resident #014 was not provided with the fall prevention interventions included in the plan of care.

During separate interviews on September 4, 5, and 10, 2018, PSWs #113 and #121, along with RPN #141 indicated that resident #014 was supposed to have the call bell accessible and functioning at all times when in the bedroom for safety.

During separate interviews on September 4 and 5, 2018, ADOC #102 and the DOC both indicated that the expectation in the home was that all residents in the home were required to have the call bell accessible and functioning at all times when in the bedroom for safety.

The licensee failed to ensure that the care set out in resident #014's plan of care was provided to the resident as specified in the plan, by not ensuring identified interventions were in place at required times. [s. 6. (7)]

Additional Required Actions:

CO # - 003 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee had failed to ensure that any plan, policy, protocol, procedure, strategy, or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with.

In accordance with O. Reg. 79/10, r.49 (1) the licensee was required to ensure that the

falls prevention and management program at a minimum provided for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices, and assistive aids.

Under O. Reg 79/10. s. 30 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Inspector #672 then reviewed the internal policy entitled "Falls Prevention"; policy number VIIG-30.00; current revision January 2015, which indicated the following:
"The Director of Care or designate will:
3) Determine a communication process by which residents at moderate or high risk for falling are easily identified to the entire care team."

Residents #002 and #007 triggered through to Stage two of the RQI, related to falls prevention, as both residents had sustained a fall in the last 30 days. Resident #014 triggered through to Stage two of the RQI related to falls prevention, related to CIR which was submitted to the Director on an identified date, related to a fall sustained, which resulted in a significant change in status . Resident #014 had also sustained a fall in the last 30 days.

Inspector #672 reviewed the plans of care for residents #002, #007 and #014. Resident #002's plan of care indicated that the resident was at high risk for falls, related to self-transferring, which resulted in previous falls with injury. Residents #007 and #014's plans of care both indicated that the residents were at moderate risk for falls.

During an interview on September 4, 2018, PSW #113 indicated that the home identified residents at moderate or high risk for falls by posting falling leaves on the wall outside the resident's bedroom.

During an interview on September 6, 2018, RPN #115 indicated that the home followed the 'falling leaf' program, which had not been consistently implemented over the last year or more, therefore it was not consistent that a resident identified to be at moderate or

high risk for falls would have a falling leaf displayed outside of their bedroom.

Inspector #672 then toured the home. On resident home areas #3 and #4, no falling leaf symbols were observed to be posted outside of any resident bedroom. On resident home areas #1 and #2, there were intermittent falling leaf symbols observed. No falling leaf symbols were observed to be posted outside of the bedrooms for residents #002, #007 or #014.

During an interview on September 4, 2018, ADOC #102 indicated that the home was supposed to be following the "falling leaf" program, but it had not been properly implemented “for quite some time”, and that the falling leaf symbols were not consistently posted for residents at risk for falls throughout the home.

The licensee failed to ensure that the internal policy entitled “Falls Prevention”; policy number VIIG-30.00; current revision January 2015, was complied with, by not ensuring that there was a communication process by which residents at moderate or high risk for falling could be easily identified by the entire care team. [s. 8. (1) (a),s. 8. (1) (b)]

2. Resident #002 triggered through to stage two of the RQI related to falls prevention, as the resident had fallen within the last 30 days. Inspector #672 reviewed resident #002’s current plan of care. The current written plan of care indicated that resident #002 was at moderate risk for falls, and a review of the progress notes revealed that the resident sustained multiple falls over an approximate, identified two month time period.

Inspector reviewed a copy of the licensee’s internal policy entitled “Falls Prevention”; policy #VIIG-30.00; current revision: January 2015, which stated the following:
“Post Falls Assessment – The Registered staff will:
4) Initiate a head injury routine if a head injury is suspected or if the resident fall is unwitnessed and is on anticoagulant therapy.

Inspector #672 then reviewed resident #002’s physical chart, and reviewed the head injury routine assessments which were completed following five identified unwitnessed falls.

During separate interviews on August 31, 2018, RPNs #106 and #109 indicated that the expectation in the home was that a head injury routine was initiated for all unwitnessed falls.

During a telephone interview on September 17, 2018, the DOC indicated that the expectation in the home regarding assessing the resident on HIR following an unwitnessed fall was that staff were expected to following the HIR guidelines at all times, even when the resident was sleeping. The DOC further indicated that the only acceptable reason to not assess the resident, and complete the HIR would be if the resident refused the assessment, but in that circumstance the staff would be expected to clearly document that the resident refused the assessment. The DOC indicated that staff writing "Resident sleeping" on the HIR document, and not assessing the resident was not considered an acceptable practice in the home, and would be in non-compliance with the licensee's policy.

The licensee failed to ensure that resident #002 was assessed as per the head injury routine guidelines following an identified number of resident falls. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy, or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care for each resident was based on an interdisciplinary assessment with respect to the resident's health conditions, including

falls risk.

Resident #007 triggered through to stage two of the RQI related to falls prevention.

Inspector #672 reviewed resident #007's current plan of care. The written plan of care in place over an identified two month period, indicated that resident #007 was at moderate risk for falls, and a review of the progress notes over the same identified period, revealed that the resident sustained three falls during that time. A review of the current written plan of care and Kardex did not identify that resident #007 was at risk for falls, or list any information for the resident specific to falls prevention.

During an interview on September 4, 2018, PSW #113 indicated being the primary PSW for resident #007 on day shift. During an interview on September 5, 2018, PSW #121 indicated being the full time primary PSW for resident #007. Both PSWs indicated not being aware if resident #007 was at risk for falls, and further indicated that resident #007 did not have any interventions in place, in an attempt to prevent further falls from occurring, as there was no information listed within the resident's plan of care regarding falls prevention.

During an interview on September 6, 2018, RPN #115 indicated that resident #007 was at risk for falls, but that information was no longer listed within the resident's plan of care, due to a new documentation system in the home. RPN #115 further indicated that staff were supposed to consider all residents in the home to be at risk for falls, and implement fall prevention interventions for all residents.

During an interview on August 28, 2018, ADOC #101 indicated that the home had recently transitioned to a new documentation system, which affected the way the resident plans of care were documented, as the written plan of care and Kardex were being pared down to only one page. ADOC #101 further indicated that the new written plans of care would only contain interventions in place for the resident that were not listed within the licensee's internal policies, such as for falls prevention. ADOC #101 indicated that interventions listed within the falls prevention policy were expected to be in place for every resident considered to be at risk for falls, and that all staff had been educated on the falls prevention policy. ADOC #101 further indicated that a focus of falls would no longer appear in a resident's written plan of care, even for residents identified to be at high risk for falls, unless the resident had an individualized intervention in place which would show up under the "Support Actions" tab in Point Click Care (PCC), and it was the responsibility of the registered staff to inform the PSW staff during shift report of the

residents who were at risk for falls.

During an interview on September 5, 2018, the DOC indicated that registered staff would review the residents who had fallen within the last 24 hours during shift report. The DOC further indicated that the staff could review each resident's Kardex, which would contain any resident specific fall prevention interventions which were not listed within the licensee's falls prevention policy, otherwise the staff were expected to follow the falls prevention policy, and implement the interventions for every resident in the home.

During a telephone interview on September 14, 2018, ADOC #102 indicated that following the RQI conducted in the home, the directions provided from the corporate office regarding the new documentation system related to each resident's falls risk and interventions no longer being listed within the plan of care had been reviewed, and indicated that the direction had changed. ADOC #102 further indicated that moving forward, the resident specific falls risk and interventions would be listed within the plan of care, which would be added to the written plans of care for residents identified as being at risk for falls during the next routine quarterly RAI-MDS assessment.

The licensee failed to ensure that resident #007's plan of care included that the resident was identified to be at moderate risk for falls, and the interventions in place in an attempt to prevent further falls from occurring. [s. 26. (3) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions, including falls risk, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #002 triggered through to stage two of the RQI related to falls prevention, as the resident had fallen within the last 30 days. Inspector #672 reviewed resident #002's current plan of care. The current written plan of care indicated that resident #002 was at moderate risk for falls, and a review of the progress notes over an approximate two month period, revealed that the resident sustained numerous falls during that time period.

Inspector reviewed a copy of the licensee's internal policy entitled "Falls Prevention"; policy #VIIG-30.00; current revision: January 2015, which stated the following:

"When a fall occurs…:
Post Falls Assessment – The Registered staff will:
7) Complete electronic post fall assessment by using the Post Fall Huddle or Fall Incident Report."

Inspector #672 then reviewed the "Assessments" section in PCC, and observed that no post fall assessments were completed related to two of the identified falls sustained over the approximate two month period.

During separate interviews on August 31, 2018, RPNs #106 and #109 indicated that the expectation in the home was that a post fall assessment should be completed after every fall sustained by a resident. RPN #106 reviewed resident #002's chart, and could not observe a post fall assessment completed after the identified two falls sustained in an

approximate two month period of multiple falls.

During a telephone interview on September 14, 2018, ADOC #102 verified that the expectation in the home was that a post fall assessment should be completed after every fall sustained by a resident. ADOC #102 reviewed resident #002's chart during the interview, and indicated that a post fall assessment could not be observed following the two identified falls sustained in an approximate two month period of multiple falls.

The licensee failed to ensure that post fall assessments were completed for resident #002. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #7: 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 has failed to ensure that drugs stored in an area or a medication cart, are used exclusively for drugs and drug related supplies and are secured and locked.

Observations of medication room A by Inspector #672 on August 29, 2018, at 1222 hours, it was noted that the nursing station door for medication room A was left wide open, with no staff members in the immediate area, at times. Within the medication storage area there were resident charts, with personal health information, sharp's containers, medication carts (which were locked). In the cupboard below the sink, Inspector #672 observed a number of unrelated items. There were no staff members observed in the area of the nursing station and medication storage area, there were two residents in the immediate area.

August 30, 2018 at 1250 hours, Inspector #623 and #672 observed the door to medication room "B" to be open and no registered staff were present in the medication room or the nursing station at the time. Inspector #623 and #672 entered the medication room B and observed that the room contained two chart racks with resident charts for all residents in two identified homes areas, as well at two computer work stations. Observations in medication room "A" indicated that same was found.

August 30, 2018, at 1301 hours, during an interview with Inspector #672, ADOC #102 confirmed that the nursing stations including the medication rooms, are considered to be non-residential areas, and the doors are to be closed and locked at all times, when there is not a registered staff member present.

On September 4, 2018, 1330 hours, Nursing Clerk (NC) #117 was observed in medication room "A" and and 1340 hours, in medication room "B" unaccompanied by a registered nurse.

On September 4, 2018, at 1340 hours, during an interview with Inspector #623, PSW #116 indicated that they knew the door code to access the designated medication storage areas, and they were able to demonstrate this by unlocking and opening the door for the Inspector. PSW #116 indicated to the Inspector, that almost all staff were aware of the door code and could access the medication room if they chose to.

On September 4, 2018, at 1350 hours during an interview with Inspector #623, NC #117 indicated that they were filing records in resident's paper charts that are stored in the

medication rooms "A" and "B". NC #117 indicated that they knew the door code to access medication rooms "A" and "B". NC indicated that most staff were aware of the door code and could access the door to the medication storage area.

On September 4, 2018, at 1400 hours during an interview with Inspector #623, ADOC #102 and DOC #100 both indicated that they were aware that most staff in the home, were aware of the door code to medication room A and B, and could access the rooms if they chose. The DOC confirmed that the identified areas medication room A and B were the designated medication storage areas for the home. The DOC indicated that the PSWs and other staff access this room because this is where the resident's charts are stored and the computer terminals are located for documentation. The DOC indicated that the PSWs and the nursing clerk are supposed to only go into that room if they are accompanied by a registered staff member.

The licensee has failed to ensure that drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug related supplies, and that is secured and locked, when it was discovered that medication storage rooms "A" and "B" both contain residents charts and computer terminals as well as items that are not drugs or drug related supplies. These rooms were left unattended and open, as well, as indicated by the DOC most staff have knowledge of the door code to unlock and access these medication storage areas, regardless of their designation. [s. 129. (1) (a)]

2. The licensee has failed to ensure that 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.

During the RQI the following observation was made:

August 30, 2018, at 1250 hours, Inspector #623 and #672 observed the door to medication room "B" to be open and no registered staff were present in the medication room or the nursing station at the time. Inspector #623 and #672 entered the medication room B and the following was observed.

In a metal cabinet with the doors unlocked
- One wooden box (approximately 2 feet high by 10 inches wide) double lock on the door of the box. The box was not secured and inspector #623 was able to pick box up. In this box there are controlled substances for destruction.

August 30, 2018, at 1310 hours, during an interview with Inspector #623, ADOC #102 indicated that the door to the medication room is to be locked at all times. The ADOC also indicated that the metal cabinet that contained medications for destruction which included the wooden box for controlled substances, is to be locked at all times. The ADOC indicated that they were unaware that the wooden box for controlled substances for destruction, was to be stationary, and confirmed that the box could be picked up and removed if a person chose to to so.

The licensee has failed to ensure that 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. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs stored in an area or a medication cart, are used exclusively for drugs and drug related supplies and are secured and locked, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use.

During the RQI the following was observed:

On August 30, 2018, at 1250 hours, Inspectors #623 and #672 observed the door to medication room "B" to be open and no registered staff were present in the medication room or the nursing station at the time. Inspectors #623 and #672 entered the medication room B and observed a number of medications in the cabinet under the sink not locked and above the sink in an unlocked cupboard a number of government medication stocked items were observed.

A metal cabinet unlocked contained an identified number of controlled substances and medications assigned for destruction.

Observation of medication room A by Inspector #623 on August 30, 2018, at 1330 hours with ADOC #102 present. The Inspector observed a tool box with a padlock on the top of a cabinet in the medication storage area. The ADOC identified this tool box as the Emergency Medication box which contains various medication but did not contain controlled substances.

August 30, 2018, at 1300 hours during separate interviews with Inspector #623, RPN #106 indicated that the medication room door is not always locked but that it is supposed to be. RPN #107 indicated that the door to the medication room is supposed to be locked when a registered nurse is not present, and that medications for destruction do not belong under the sink.

August 30, 2018, at 1310 hours during an interview with Inspector #623, ADOC #102 indicated that the door to the medication room is to be locked at all times. The ADOC also indicated that all medications for destruction, belong in the Stericycle bucket and should not be stored under the sink in the medication room. The ADOC also indicated that the cupboards that contain medications for destruction which includes the wooden box for controlled substances, as well as the Government Pharmacy stock medications, are to be locked at all times. The ADOC indicated that they were unaware that the wooden box for controlled substances for destruction, was to be stationary.

August 30, 2018, at 1330 hours, during an interview with Inspector #623, the Executive Director (ED) indicated that the expectation is that all medication storage areas are locked and that only staff who are permitted to administer medications have access to the medication storage rooms.

The licensee failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use. [s. 130. 1.]

2. The licensee failed to ensure that all areas where drugs are stored are restricted to the persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On September 4, 2018, 1330 hours, Nursing Clerk (NC) #117 was observed in medication room "A" and and 1340 hours, in medication room "B" unaccompanied by a registered nurse.

On September 4, 2018, at 1340 hours, Inspector #623 inquired if PSW #116 could access the medication room "B". The PSW initially indicated that they could not, the PSW then indicated that they knew the door code and could open the door for the Inspector, but were not supposed to go into the room. PSW #116 indicated that almost all staff were aware of the door code and could access the medication room if they chose to. PSW #116 then opened the door of medication room "B" for Inspector #623, where NC #117 was discovered alone inside the room with no registered nursing staff present.

On September 4, 2018, at 1340 hours, during an interview with Inspector #623, NC #117 indicated that they were filing records in resident's paper charts that are stored within the medication room. NC #117 indicated that they knew the door code to access medication rooms A and B. NC indicated that most staff were aware of the door code and could access the door to the medication storage area. NC #117 indicated that they were not a doctor or a nurse, and were not permitted to administer dispense, prescribe or medications.

On September 4, 2018, at 1350 hours, during an interview with Inspector #623, ADOC #102 and DOC #100 both indicated that they were aware that most staff in the home, were aware of the door code to medication room A and B, and could access the rooms if they chose. The DOC confirmed that the identified areas medication room A and B were the designated medication storage areas for the home. The DOC also indicated that they were aware that these storage areas should only be accessed by staff permitted to

dispense, prescribe or administer medication and the Administrator. The DOC indicated that this is a past practice in the home before the DOC and ADOC began working in the home. The DOC indicated that the PSWs and other staff access this room because this is where the resident's charts are stored. The DOC indicated that the PSWs and the nursing clerk are supposed to only go into that room if they are accompanied by a registered staff member.

The licensee failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home and the Administrator. [s. 130. 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 all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During stage two of the RQI a review of the medication incidents that were reviewed at the last medication management meeting was completed by Inspector #623. This meeting took place in June, 2018. The most recent medication incident was selected for further review. The following incident occurred on an identified date.

On an identified date resident #018 received the order for three identified treatment/medications. All three items prescribed were not covered under the Ontario Drug Benefit plan and required the SDM consent to pay. The usual pharmacy process is to schedule the non-covered treatment A 1 to 2 weeks from the date of order, to allow time for obtaining consent and processing of the medications. In most cases, the buffer time allotted is sufficient for pharmacy staff to reach the SDM, obtain payment approval and dispense the medication. The dose of treatment A was scheduled to be administered on an identified date.

On the identified date, treatment A was administered to resident #018 as scheduled. RPN #103 administered the treatment using a stock supply that was available from Public Health funded stock, that was on hand in the home and was not able to be returned. This treatment was administered and documented in an identified section of the residents chart in Point Click Care (PCC).

Seven days later, the home's contracted pharmacy obtained consent from the SDM for resident #018, for payment of unfunded items that were prescribed weeks prior. The pharmacy had never dispensed the initial treatment A, therefore the pharmacy staff interpreted that treatment A was still required. The contracted pharmacy dispensed treatment A to the home and scheduled the does to be administered on an identified date.

On the identified date, 2018, RPN #107 administered the scheduled treatment A to resident #018. When RPN #107 attempted to document that treatment A had been administered in PCC, it was discovered that treatment A had been previously administered to resident #018 nine days prior, by RPN #103.

August 30, 2018, at 1245 hours, during an interview with Inspector #623, RPN #107 indicated that on an identified date, they administered treatment A to resident #018 that was scheduled to be administered in the eMAR. RPN #107 indicated that after treatment A was administered, they signed on the eMAR and then went to record in the specific area in PCC. This is when RPN #107 discovered that treatment A had been administered nine days prior, by RPN #103. RPN #107 indicated that they immediately notified ADOC #102, the pharmacy, physician and the SDM. RPN #107 indicated that the physician ordered monitoring of the residents vital signs and for any change in condition including cognition for 24 hours. RPN #107 indicated that no concerns were brought forward by the resident or SDM.

RPN #103 was not available for interview.

August 29, 2018, at 1400 hours, during an interview with Inspector #623, ADOC #102 indicated that when RPN #107 administered the treatment A and discovered that it had already been administered, the RPN immediately reported to ADOC #102 the occurrence. The ADOC indicated that the pharmacy and physician were immediately contacted for direction. The SDM and the resident were also notified of the incident. The physician instructed that the resident was to be monitored every shift for 24 hours for any feelings of being unwell as well as vital signs. The pharmacy indicated to ADOC #102 that the body would only use what it needed of the treatment A, and would "spill" the rest. ADOC #102 indicated that the resident and the SDM did not bring forward any concerns. The ADOC indicated that the outcome of the investigation into this medication incident identified that there was a breakdown in the system of notification between the pharmacy and the home when a medication is administered by using an alternative source. Moving forward, nursing staff were now required to identify on the original order sheet, where the dose of the medication was being supplied from. The ADOC indicated that the expectation was that registered staff will complete checks to ensure the physician order is accurate and that treatments, like treatment A had not been previously administered.

The licensee failed to ensure that treatment A was administered to resident #018 as prescribed, when resident #018 received a second dose of the treatment A nine days after the initial dose. [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 #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

On an identified date, Inspector #672 observed a nourishment pass on unit #2, being completed by PSW #105. PSW #105 was observed to be entering and exiting resident rooms to serve the refreshments and collect dirty dishes, place dirty cups on the second level of the nourishment cart, and physically assist two residents with their nourishment, but no hand hygiene was observed being completed.

During an interview PSW #105 indicated their understanding of the expectation in the home regarding hand hygiene during the nourishment pass was that hands were to be cleaned using one of the sanitization stations in the hallway at the initiation of the nourishment pass, and then again once the entire nourishment pass had been completed, but was not required during completion of the nourishment cart.

On another identified date during the inspection, Inspector #672 observed another nourishment pass on unit #2, being completed by PSW #111 and PSW #112. PSW #111 was observed to be assisting two residents with their nourishment, and no hand hygiene was observed being completed between assisting either resident. PSW #111 then went on to deliver the morning nourishments down the unit #2 hallway, to the

residents in their room. No hand hygiene was observed until PSW #111 exited the second bedroom. PSW #112 was observed to be assisting PSW #111 administer nourishment to the residents in their bedrooms, but was not observed to complete any hand hygiene prior to beginning the nourishment pass. PSW #112 entered an identified room with two glasses of juice, then assisted one of the residents from the bedroom area to the open area by the nursing desk, by assisting with pushing their wheelchair. Once the resident was situated comfortably, PSW #112 returned to the nourishment cart, and prepared two more glasses of juice. No hand hygiene was observed until after the glasses of juice were poured.

During an interview PSW #111 indicated that there was a bottle of hand sanitizer available for use on the nourishment cart, and the expectation in the home was that the sanitizer was to be used at the beginning and end of the nourishment pass, or after assisting with feeding a resident.

During an interview PSW #112 indicated that the expectation in the home regarding hand hygiene during the nourishment pass was that hands were to be sanitized between each resident who received a refreshment.

On an identified date during the inspection, Inspector #672 observed part of the afternoon nourishment pass on units #1 and #2. On Unit #2, the nourishment cart was observed between identified room, which was being completed by PSWs #118 and #119. Both PSWs were observed to administer refreshments to multiple residents, bring out dirty dishes from resident bedrooms, and physically assist residents to consume their snack. PSW #118 was observed to assist a resident by feeding them a cup of yogurt, and PSW #119 was observed to assist a resident to consume a beverage. No hand hygiene was observed to be completed before or after assisting any of the residents between rooms, by either PSW. The nourishment cart on unit #1 was being completed by PSW #120 and PSW #121. No hand hygiene was observed being completed by either PSW, during the observation. PSW #120 was observed to be removing dirty dishes from resident rooms, and PSW #121 was observed to be entering multiple resident rooms, and fed one resident a cup of yogurt, and another resident a fortified drink.

During separate interviews PSW #118 and #119 both indicated that the expectation in the home was that hand hygiene was to be completed between serving each resident. PSW #120 indicated that the expectation in the home was that hands were to be cleaned at the beginning of the nourishment cart, and PSW #121 indicated that the expectation in the home was that hands were to be washed between assisting/serving each resident,

but hand hygiene had not been completed during this nourishment pass, due to it slipping their mind.

On another identified date during the inspection, Inspector #672 observed the afternoon nourishment pass on unit #1, which was completed by PSW #121 and PSW #123. Both PSWs were observed to be entering/exiting resident's rooms, removing dirty dishes from the bedroom area, and assisting residents consume their nourishment. PSW #123 was also observed to pick up the cookies being served to the residents with their bare hands and place them on a napkin, instead of using the tongs provided. No hand hygiene was observed to be completed at all by either PSW during the observation.

During an interview PSW #123 indicated that the expectation in the home regarding hand hygiene during the nourishment pass was that hands only needed to be washed at the initiation of the nourishment cart.

Inspector #672 observed part of the nourishment pass being completed on unit #3, which was completed by PSW #127. PSW #127 was observed to serve several residents while they were sitting by the nursing desk, and physically assisted one resident to eat a cup of yogurt. After serving the residents seated at the nursing station, PSW #127 was observed to go down the unit #3 hallway, and begin to serve residents in their bedrooms. No hand hygiene was observed to be completed during the observation.

During an interview PSW #127 indicated that the expectation in the home was that staff utilize the hand sanitizer between serving each resident.

On two identified dates during the inspection Inspector #672 observed the residents being taken into the dining room for the first and second seating of the lunch meal. No hand hygiene was observed being completed when the residents were brought into the dining room, and no hand hygiene was observed at the tables, prior to fluids and the meal being served.

During an interview the DOC indicated that the expectation in the home was that hand hygiene was to be completed between assisting each resident, while completing the nourishment pass. The DOC further indicated that residents were to have hand hygiene performed prior to entering the dining room for meal service.

The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program, by completing hand hygiene during the

nourishment passes, and ensuring that residents receive hand hygiene prior to meal service. [s. 229. (4)]

2. The licensee has failed to ensure that symptoms indicating the presence of infection in residents were recorded on every shift.

Resident #012 triggered through to stage two of the RQI, related to an identified area of altered skin integrity.

Inspector #672 reviewed the progress notes for resident #012 over an identified10 day period, which revealed that on the evening shift of an identified date, resident #012 was noted to be exhibiting symptoms of an infection.

Inspector #672 reviewed the Physician's orders for resident #012, which indicated that resident #012 was placed on an identified treatment.

Inspector #672 then reviewed the progress notes and vital signs sections of Point Click Care over an identified period, and noted that there was no documentation related to resident #012's symptoms on seven identified shifts as was required.

Inspector #672 continued to review resident #012's progress notes, related to altered skin integrity concerns and observed a progress note on an identified date, which indicated a concern, therefore the nurse practitioner ordered a treatment.

Inspector #672 then reviewed the Physician's orders for resident #012, which indicated that resident #012 was placed on an identified treatment with the first dose to be administered on an identified date and time.

Inspector #672 then reviewed the progress notes and vital signs sections of Point Click Care over an identified period, and noted that there was no documentation related to resident #012's symptoms on nine identified shifts as was required.

During separate interviews on September 5, 6, and 7, 2018, RPNs #106, #115, #132, #133, and #141 all indicated that the expectation in the home was that while a resident was ill, exhibited symptoms of an infection and on an identified treatment, the resident was to be assessed and documented on every shift.

During an interview on September 5, 2018, the DOC verified that that the expectation in

the home was that while a resident was ill, exhibited symptoms of an infection and on an identified treatment, the resident was to be assessed and documented on every shift.

The licensee failed to ensure that when resident #012 became ill and exhibited symptoms of an infection and a wound infection, that staff recorded the symptoms on every shift. [s. 229. (5)]

3. Related to Log #003982-17:

A complaint was received by the Director on an identified date, from resident #015's Substitute Decision Maker (SDM), who alleged that resident #015 passed away as a result of a medical concern related to an identified area of altered skin integrity, which had been acquired in the home, and present for an identified extended period of time.

Inspector #672 completed a record review for resident #015 related to skin and areas of altered skin integrity. Inspector #672 requested past copies of all of the skin assessments which were completed over an identified period of time. In an identified month there was an assessment which indicated that there was a recurrence of an area of altered skin integrity, which was described. Approximately three months later the area of altered skin integrity was assessed and documented to have progressed to a worsened state. A review the Physician's orders, which revealed that resident #015 was started on a treatment for the medical condition.

Inspector #672 then reviewed the progress notes and vital signs sections of Point Click Care over a five day period and noted that there was no documentation related to resident #015's symptoms on two identified shifts.
Inspector #672 then reviewed the progress notes and vital signs sections of Point Click Care over a later 16 day period and noted that there was no documentation related to resident #015's symptoms on four shifts. A following review of another 10 day period whereby resident #015 still presented with an infection and was receiving treatment revealed no documentation related to resident #015's symptoms on three shifts.

During separate interviews on September 5, 6, and 7, 2018, RPNs #106, #115, #132, #133, and #141 all indicated that the expectation in the home was that while a resident was ill, experiencing identified symptoms of infection and on treatment, the resident was to be assessed and documented on every shift.

During an interview on September 5, 2018, the DOC verified that that the expectation in the home was that while a resident was ill, experiencing symptoms of infection and on treatment, the resident was to be assessed and documented on every shift.

The licensee failed to ensure that when resident #015 became ill and exhibited symptoms of an infection, that staff recorded the symptoms on every shift. [s. 229. (5) (b)]

Additional Required Actions:

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

WN #11: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a report to the Director regarding a reportable incident included the full name of the staff member who discovered the incident.

Related to Log #008586-18:

A CIR was submitted to the Director on an identified date, related to a fall sustained by resident #014. According to the CIR, resident #014 was transferring independently and lost their balance, which resulted in the fall. Upon assessment, resident #014 was complaining of pain, therefore was transferred to hospital for further assessment. Resident #014 was admitted to the hospital with a significant change in status.

Inspector #672 reviewed the progress notes for resident #014 on the day of the fall, which described how the resident #014 was found by an identified PSW staff member. Inspector #672 then reviewed the CIR, and observed that the CIR only listed "PSW" as the staff member who discovered the incident, and did not include the staff member's full name as required.

The licensee failed to ensure that the CIR submitted to the Director regarding a fall sustained by resident #014, which resulted in a significant change in status, included the full name of the staff member who discovered the incident. [s. 107. (4) 2.]

Issued on this 27th day of February, 2019

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANE BROWN (110), JENNIFER BATTEN (672), SARAH GILLIS (623)
Inspection No. / No de l'inspection :	2018_414110_0013
Log No. / No de registre :	006810-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 26, 2019
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Altamont Care Community 92 Island Road, SCARBOROUGH, ON, M1C-2P5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jane Smith

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with the LTCHA, 2007, s. 15(2).

Upon receipt of this order the licensee must ensure the following are completed:
1. Develop and implement a process to ensure regular and deep cleaning of walls, baseboards, floor transitions and air exchange vents.
2. Conduct ongoing weekly audits. The weekly audits must be completed by rotating management staff and include an audit of all areas identified in item #1 along with resident room washrooms.
3. Develop an action plan for each weekly audit with time frames for completion of the identified cleaning concerns and the person responsible for cleaning. The action plan shall include areas for staff signature to acknowledge when the cleaning has been completed.
4. A record will be kept of each audit and action plan for review by inspector for one year upon receipt of this order.

Grounds / Motifs :

1. The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

This inspection protocol triggered during stage one of the RQI related to a family interview and concerns around the cleanliness of resident #002's room and the cleanliness of the Long Term Care home in general.

On August 29, 2018 at 1445hrs an initial observation of resident #002's room, was completed by inspector #110. Subsequent observations with the same findings were made on August 30, 2018 at 1319hrs and August 31, 2018 at 1100hrs with inspector #623.
The observations were noted as follows:

Identified room A
-Wall under sink, visible from residents bed was soiled with circular brown splatters markings ranging in size from a quarter to a dollar coin.
-Tile floor around head of bed and side table, had dark brownish-black build up irregular patches and appeared soiled. Inspector #110 was able to wipe clean with a wet paper towel.
-Wall/flooring joints (especially in corners) and flooring thresholds (transition piece from hall to resident's room and resident's room to bathroom) were soiled with thick dark brownish-black build up.
-Toilet base – light -brown staining was observed surrounding base of toilet (query rust or stool). Floor in bathroom stained with dark irregular patches and fluid drips with the appearance of being unclean.
-Hallway wooden baseboard outside room 405 and running between rooms 403 and 407 were soiled with what appeared to be beige dried food and brown beverage spill markings.
Further hallway observations were made of Wing 4 and Wings 1-3 with the following observations:
-Flooring thresholds (transition piece from hall to resident rooms) were identified as soiled with dark brownish-black build up entering rooms 402, 404, 406, 405, 408, 410, 412, 414, 416, 419, 415 and 409.
-Wall air exchange vents between rooms 419-417 and 311-309 were observed with heavy amounts of visible grey dust and debris. The wall air exchange vent located across from The Rouge room near the reception, measuring approximately three feet wide above baseboard to chair rail was heavily soiled with thick dust and drip markings appearing like brown beverage spills . The area where the air exchange vent meets the baseboard was soiled with the appearance of brown beverage drips.

Wooden baseboards were soiled with dried food and beverages spill markings running throughout the home in identified areas.

The observations were noted as follows:
Wing #1
-Vent outside room 118 and between rooms 113-115 were observed with a heavy amount of visible grey dust and debris.
-Door hallway transitions to rooms 118, 114, 108, 103, 104, and 102 were identified as heavily soiled with dark brownish-black build up.
-Wooden baseboards between rooms 118-116, outside 113, between rooms 111-109, 114-112, 109-107, 110-112, 108-106, 106-104, 103-105 and between room 105 and the shower room entrance were soiled with dried food and beverages spill markings.

Wing #3
-Vent outside room 311 was observed with heavy amounts of visible grey dust and debris.
-Door- hallway transitions of rooms 318, 311, 316, 3015, 312, 303, 310, 308 were identified as soiled with dark brownish-black build up.
-Wooden baseboards between rooms 311-309, outside rooms 314, 314-312, 312-310 and 308-306 were soiled with dried food and beverages spill markings.

Wing #2
-Hallway wall outside the program room, measuring approximately eight feet in length from the baseboard up the wall to the chair rail had many areas of green substance dried to the wall. The tile in the same area measuring approximately 12 inches from the floor up the wall was soiled with scuffed marks the entire length appeared dirty with dark markings and stains. The wooded baseboard above the tile had beige and dark brown dried food and liquid spills.
-Vent outside room 204 and 220 was observed with heavy amounts of visible grey dust and debris.
-Doorway transitions into rooms 204, 206, 208, 210, 207, 212, 209 and 218 were identified as soiled with dark brownish-black build.
-Wooden baseboards outside room 201, between rooms 201-203, 202-204, 203 -205, 204-206, 210-212, 205 to the entrance of the bath area; outside rooms 207, 220, 216, 215, between 211-213 and 213-215 were soiled with dried food and beverages spill markings.
On August 31, 2018 at 1115hrs a tour was conducted with the home's Executive Director who confirmed the areas where soiled and represented a build-up beyond a monthly deep cleaning.

On August 31, 2018 at 1237hrs an interview with held with the newly appointed Environmental Services Manager (ESM), who had been in the position for an identified period of time. The interview revealed that they were, at that time, unaware of the deep cleaning requirements of the housekeeping staff. A tour was conducted with the ESM to observe an identified resident room, floor transitions from hallway to resident rooms; rooms to bathrooms; vents, wooden baseboards and floor stains. The ESM confirmed that the areas had not been cleaned daily or deep cleaned as expected by staff and the cleanliness of the home "was not up to standard".

The deep cleaning of floor transitions and baseboards was observed to begin upon return to the home on September 3, 2018.

The severity of this issue was determined to be a level 1 as there was minimum risk. The scope of the issue was a level 3 as it was widespread. The home had a level 2 compliance history as there was previous unrelated non-compliance .

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(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 must be compliant with O. Reg. 79/10, s. 50. (2).
The licensee is ordered to:
1) Develop and implement a plan to ensure that when any resident exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds; (a) The resident is assessed by the 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. (b) The resident is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
2) Audit the Treatment Administration Records on a monthly basis for a six month period of time, to identify residents exhibiting new areas of altered skin integrity. If there are residents with new areas of altered skin integrity noted, ensure a referral to the RD was completed and the resident was assessed by the RD.
3) Keep a documented record of the audits conducted.
4) Develop and implement a plan which outlines corrective actions taken and by whom, if staff fail to implement the interventions as identified.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was 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 were implemented.

Resident #012 triggered through to stage two of the RQI, related to the presence of an area of altered skin integrity.

During a record review, Inspector #672 reviewed resident #012's progress notes, which revealed that an area of altered skin integrity was first noted on an identified date on resident #012's body. Inspector #672 then further reviewed resident #012's progress notes, which indicated that weeks later, resident #012 was observed with a second area of altered skin integrity, and a month later a third area was noted. No progress notes were observed to indicate that the resident had been assessed by a RD following the observations of any of resident #012's skin integrity concerns.

Inspector #672 then reviewed the licensee's internal policy entitled "Skin & Wound Care Management Protocol"; policy number: VII-G-10.80.SSLI; current revision: April 2018, which indicated the following: "Registered staff will:
4) With a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds:
c. Refer resident to the Registered Dietitian and other interprofessional team members, as required."

The policy went on to state the following:

"The Registered Dietitian will:
1) Assess residents exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears, or wounds.
2) Change resident's plan of care as needed relating to nutrition and hydration.
3) Make referrals as appropriate for the resident to Physician/NP, including further blood work and vitamins/minerals needed.

During an interview on September 6, 2018, RN #128 indicated that staff would not always send a referral to the RD when altered skin integrity was observed, if the resident was already being followed by the RD, which was the belief in why a referral was not sent for resident #012.

During a telephone interview on September 14, 2018, ADOC #101 indicated being responsible for the skin and wound program in the home. ADOC #101 further indicated that the expectation in the home was that referrals should be sent to the RD immediately following confirmation that the resident had an area of altered skin integrity, so that the resident exhibiting altered skin integrity could be assessed by the RD. ADOC #101 further indicated being aware that sometimes if the resident was already receiving a nutrition intervention or was being followed by the RD for another reason outside of skin integrity concerns, some nurses would not send a referral related to an impaired skin integrity concern. ADOC #101 indicated that if the nurse made that judgement, they would be considered to be in non-compliance with the licensee's policies, and follow up with the nurse to remind them of the need for a referral to be sent, to ensure the RD was aware of the most updated information regarding the resident's skin integrity, to assist in ensuring that the resident received an RD assessment.

During an interview on September 6, 2018, the DOC indicated that an RD assessment was required for all residents exhibiting altered skin integrity.

During an interview on September 10, 2018, the RD indicated that a referral was not sent following the initial observation of resident #012's altered skin integrity nor the two subsequent areas of altered skin integrity and therefore assessments were not completed specific to the resident's skin integrity. The RD further indicated that even when a resident was already receiving a nutritional intervention or being followed by the RD for another reason, a referral was still required for any new observation of altered skin integrity, as a new assessment of the resident would be completed, and the nutritional plan of care would often be changed, in account of the resident's increased nutritional needs, in order to promote healing.

At the time of this inspection, September 10, 2018 resident #012 continued to exhibit areas of altered skin integrity.

The licensee failed to ensure that when resident #012 was first noted to exhibit altered skin integrity, that the resident was assessed by a Registered Dietitian. [s. 50. (2) (b) (iii)]

(672)

2. The licensee has failed to ensure that resident #012 was reassessed at least weekly by a member of the registered nursing staff when the resident was exhibiting altered skin integrity, which included pressure ulcers and skin tears.

Resident #012 triggered through to Stage two of the RQI, related to the presence of an area of altered skin integrity.

During the record review in Stage II of the RQI, resident #012's clinical health records indicated that resident #012 had an identified area of altered skin integrity, which had been present since an identified date, and a second

identified area of altered skin integrity present since another identified date.

During an interview on September 4, 2018, the DOC indicated the expectation in the home was that every identified area of altered skin integrity should be assessed and documented on, on a weekly basis.

Inspector #672 reviewed resident #012's progress notes, which revealed that an area of altered skin integrity was first noted on an identified date. Inspector #672 then reviewed resident #012's progress notes, which indicated that on an identified date, resident #012 was observed to have a second area of altered skin integrity, and weeks later a third area. Inspector #672 then reviewed resident #012's skin and wound assessments between a two month period, which revealed three identified weeks whereby there was no documentation to support that the resident's identified areas of altered skin integrity were assessed by the registered staff and no documentation to support that the resident's second and third areas of altered skin integrity was assessed weekly by the registered staff.

During an interview on September 6, 2018, RN #128 indicated that the expectation in the home was that a weekly skin assessment should be completed for any resident who was exhibiting altered skin integrity, and that the registered staff had received education regarding when and how to complete the weekly skin assessments.

During a telephone interview on September 14, 2018, ADOC #101 indicated being the lead for the skin and wound program in the home. ADOC #101 verified that the expectation in the home was that a weekly skin assessment should be completed for any resident who was exhibiting altered skin integrity.

The licensee failed to ensure that resident #012 was reassessed at least weekly by a member of the registered nursing staff when the resident was exhibiting altered skin integrity. [s. 50. (2) (b) (iv)]

(672)

3. Related to Log #003982-17.

A complaint was received by the Director on an identified date, from resident #015's Substitute Decision Maker (SDM), who alleged that resident #015 passed away as a result complications to an area of altered skin integrity, which had been acquired in the home. The complainant further indicated that the staff did a very poor job of managing and treating the area of altered skin integrity, which had led to a complication.

Resident #015 had identified areas of altered skin integrity.

During an interview on September 4, 2018, the DOC indicated the expectation in the home was that every identified area of altered skin integrity was to be assessed by the registered staff, and documented on a weekly basis, which included measurements of the identified areas.

Inspector #672 completed a record review for resident #015 related to their skin condition and requested past copies of all of the skin assessments.
For altered area of skin integrity identified as A, no weekly assessments were observed on 14 occasions over an eight month period. For altered area of skin integrity identified as B, no weekly assessments were observed on eight occasions over a two month period.

During a telephone interview on September 14, 2018, ADOC #101 indicated being the lead for the skin and wound program in the home. ADOC #101 verified that the expectation in the home was that a weekly skin assessment should be completed for any resident who was exhibiting altered skin integrity.

The licensee failed to ensure that resident #015's identified areas of altered skin integrity were reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

The severity of this issue was determined to be a level 3 actual harm/risk as resident #012 had three consecutive areas of altered skin integrity, including two pressure ulcers not referred to and assessed by the RD that remained unhealed. The scope of the issue was a level 3 widespread, as it related to three of three residents reviewed.

The home had a level 3 compliance history as there was one related non compliance within the last three years that included:
-voluntary plan of correction (VPC) issued May 18, 2016 in report #2016_251512_0005 related to r. 50. (2)(b)(iv).
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with the LTCHA, 2007, s. 6 (1).
The licensee is ordered to:
1) Develop and implement a plan for to ensure the written plan of care for residents #002, #012 and #014, and any other resident in the home who is at risk for falls and/or altered skin integrity, sets out clear directions to staff and others who provide direct care to the resident.
2) Develop and implement an auditing process to ensure that the written plan of care for all residents in the home sets out clear directions to staff and others who provide direct care to the resident.
3) Keep a documented record of the audits conducted.
4) Develop and implement a plan which outlines corrective actions taken and by whom, if staff fail to implement the interventions as identified.

Grounds / Motifs :

1. The licensee has failed to ensure that the written plan of care for each resident sets out clear directions to staff and others who provided direct care to the residents.

Resident #002 triggered through to stage two of the Resident Quality Inspection (RQI) related to falls prevention.

During an interview on August 31, 2018, Physiotherapist (PT) #110 indicated that resident #002 required described assistance for transfers. PT #110 further indicated that the transfer status of each resident was communicated to staff

through transfer logos being posted above the bed for each resident, along with being listed within the Kardex and the written plan of care. PT #110 indicated that it was their responsibility to post the transfer logos above each resident's bed in the home, and the logo should be signed and dated by the PT once it was posted. This information would then be communicated to the RPN, who would ensure that the written plans of care and Kardex for the resident were kept current.

Inspector #672 reviewed resident #002's current written plan of care which indicated the resident's level of transfer assistance. The Inspector then reviewed the "Support Actions" section of PCC, which created the Kardex for PSW staff to review. The Kardex stated the resident required a different level of transfer assistance. Inspector #672 then observed the transfer logo posted above resident #002's bed. The transfer logo identified an incorrect level of transfer assistance. Inspector #672 observed the transfer logos posted above the beds of residents #021 and #022. PT #110 verified that the logos currently hanging above the bed for residents #002 and #021 were not the correct level of transfer status for the resident.

Inspector #672 then reviewed the plan of care for resident #021. According to the logo above resident #021's bed, the resident required an identified transfer intervention. Inspector #672 reviewed the resident's current written plan of care, which indicated that the resident required a different intervention with transfers.

During an interview on August 31, 2018, Physiotherapist (PT) #110 indicated that resident #021 shared the resident transfer status, and revealed that the transfer logo above the bed and the written plan of care were not correct, regarding the transfer status of the resident.

During an interview on August 30, 2018, PSW #104 indicated that resident #002 required two staff members to assist during each transfer. PSW #104 further indicated that staff would review the Kardex, the written plan of care, and look for signs posted above the resident's bed to provide direction to the staff regarding the resident's care needs, and when there was confusion between the areas, staff would go to the nurse to clarify.

During an interview on August 31, 2018, ADOC #102 indicated that the PSW

staff should refer to the transfer logo above the resident's bed for the most up to date and current transfer status of the resident. ADOC #102 further indicated that the transfer logo above the resident's bed should contain the same directions as that listed within the resident's Kardex and written plan of care, and indicated that clear direction was not provided regarding the transfer status of residents #002 and #021.

The licensee failed to ensure that resident #002 and #021's plan of care set out clear directions to staff and others who provided direct care to the resident, specific to the resident's transfer status. [s. 6. (1) (c)]

(672)

2. Related to Log #008586-18:
A Critical Incident Report (CIR) was submitted to the Director on an identified date, related to a fall sustained by resident #014 on an identified date and time. According to the CIR, resident #014 was transferring independently and lost their balance, which resulted in a fall. Upon assessment, resident #014 was complaining of pain to an identified area, therefore was transferred to hospital for further assessment, where the resident was admitted with a significant change in status.

Inspector #672 reviewed resident #014's plan of care in place at the time of the fall. The written plan of care, indicated that resident #014 was at high risk for falls due to attempting to transfer independently. A review of the progress notes over an identified period revealed that the resident sustained two falls during that time period. Following the first fall, four interventions were included in the plan of care. Inspector #672 then reviewed resident #014's progress notes over the next two month period which indicated that resident #014 had sustained two more falls. Inspector then reviewed resident #014's current plan of care. The written plan of care no longer identified that resident #014 was at risk for falling, and no interventions were listed. The Kardex did not indicate that resident #014 was at risk for falls, but did list that an identified intervention was required when up in the wheelchair.

During an interview on August 28, 2018, ADOC #101 indicated that the home

had recently transitioned to a new documentation system, which affected the way the plans of care were documented, as the written plan of care and Kardex were being pared down to only one page. ADOC #101 further indicated that the new written plans of care would only contain interventions in place for the resident that were not listed within the licensee's internal policies, such as for falls prevention. ADOC #101 indicated that interventions listed within the falls prevention policy were expected to be in place for every resident considered to be at risk for falls, and that all staff had been educated on the falls prevention policy. ADOC #101 further indicated that a focus of falls would no longer appear in a resident's written plan of care, even for residents identified to be at high risk for falls, unless the resident had an individualized intervention which would show up under the "Support Actions" tab in Point Click Care (PCC), and it was the responsibility of the registered staff to inform the PSW staff during shift report of the residents who were at risk for falls.

During a telephone interview on September 14, 2018, ADOC #102 indicated that following the RQI conducted in the home, the directions provided from the corporate office regarding the new documentation system related to each resident's falls risk and interventions no longer being listed within the plan of care had been reviewed, and indicated that the direction had changed. ADOC #102 further indicated that moving forward, the resident specific falls risk and interventions would be listed within the plan of care, which would be added to the written plans of care for residents identified as being at risk for falls during the next routine quarterly RAI-MDS assessment.

The licensee failed to ensure that resident #014's plan of care set out clear directions to staff and others who provided direct care to the residents, related to the residents falls risk. [s. 6. (1) (c)]

(672)

3. Resident #012 triggered through to stage two of the RQI, related to the presence of an altered area of skin integrity.

During the record review in Stage II of the RQI, resident #012's clinical health records indicated that resident #012 had two areas of altered skin integrity.

Inspector #672 reviewed resident #012's electronic medication administration record (eMAR) and electronic treatment administration record (eTAR) for an identified month. During the review, it was revealed that there were two separate physician's orders related to the treatment for the same area of altered skin integrity. One of the orders stated directions related to an area of altered skin integrity in location A of the resident, and the other order stated directions related to an area of altered skin integrity in location B of the resident.

Inspector #672 then reviewed the progress notes and skin assessments for resident #012 in the same identified time period. The documentation indicated resident #012 had only one area of altered skin integrity not two as the orders implied.

During an interview on September 7, 2018, RN #128 indicated that they had assessed the resident's area of altered skin integrity in an identified month, at which time the resident had one area of altered skin integrity, and had only been aware of the resident having one area.

Upon review of the eMAR, Inspector #672 observed that both orders had been signed to indicate the treatments had been administered four times in an identified month.

Inspector #672 then reviewed the staffing schedule, and verified with the receptionist and DOC that RPN #132 had worked during some of the shifts, and RPN #133 had worked the shift on one of the shifts.

During a telephone interview on September 7, 2018, RPN #132 verified signing both orders to indicate the treatments had been administered. RPN #132 indicated that when the treatments had been completed for resident #012, the resident only had one area of altered skin integrity. RPN #132 further indicated that the directions listed under the physician's order for the area of altered skin integrity A had been followed, not the directions listed for the area of altered skin integrity B, and found that having two treatment orders for resident #012 listed on the eMAR had been very confusing. RPN #132 indicated that the expectation in the home, and from the College of Nurses of Ontario, was that nurses were not to document or sign for medications or treatments which had not been

provided to the resident. RPN #132 indicated that instead of signing both orders to indicate they had been administered, the orders could have been clarified with the RN or the physician, and the incorrect order should have been removed from the resident's eMAR to prevent further confusion, but this was not done, due to time constraints.

During a telephone interview on September 7, 2018, RPN #133 verified signing both orders to indicate the treatments had been administered on an identified date. RPN #132 indicated that when the treatment had been completed for resident #012, there had only been one area of altered skin integrity and they had followed the directions listed under the physician's order for the wound altered skin integrity A. RPN #133 further indicated being very confused during resident #012's dressing change, due to having two different physician's orders listed, when the resident only had one area of altered skin integrity. RPN #133 indicated that they did not stop to verify the order with the RN or physician prior to completing the treatment, although there had been an RN available, and that it was not part of their usual practice to sign an order if it was not completed and/or administered to the resident as per the directions. RPN #133 indicated that the expectation in the home, and from the College of Nurses of Ontario, was that nurses were not to document or sign for medications or treatments which had not been provided to the resident.

During an interview on September 7, 2018, the DOC reviewed the orders listed in resident #012's eMAR and eTAR in an identified month. The DOC indicated that after reading the physician's orders, they would have expected that resident #012 had two separate areas of altered skin integrity, based on how each of the areas were described in the physician's orders; along with the differences in where the altered area was documented to be located. The DOC indicated finding the physician's orders very confusing, and due to the fact that resident #012 had only one area of impaired skin integrity present in the identified month, clear directions had not been provided to the staff who were caring for resident #012. The DOC further indicated that the expectation in the home was that if the registered staff had questions surrounding an order, or if the order was ambiguous or unclear in any way, the nurse should contact the physician prior to carrying out the order, and then only sign the eMAR/eTAR for the order which had actually been completed. The DOC indicated that if there was a physician's order visible in the eMAR or eTAR which was incorrect or inaccurate, the

expectation in the home was that the nurse should clarify the order, and then either correct or discontinue the order, as required, and that the internal processes had not been followed in this circumstance.

The licensee failed to ensure that resident #012's plan of care set out clear directions to staff and others who provided direct care to the resident, specific to the treatment of the resident's area of altered skin integrity. [s. 6. (1) (c)]

The severity of this issue was determined to be a level 2 minimal harm or potential for actual harm. The scope of the issue was a level 3, widespread as it related to three of three residents reviewed.
The home had a level 3 compliance history as there was one or more related non compliance within the last 3 years that included:
-voluntary plan of correction (VPC) issued June 20, 2018 in report #2018_378116_0008 related to s. 6. (7).
-voluntary plan of correction (VPC) issued February 15, 2018 in report #2018_630589_0001 related to s. 6. (4) (a) and s. 6. (7).
-voluntary plan of correction (VPC) issued January 25, 2017 in report #2016_377502_0017 related to s. 6. (1)(a), s. 6. (10)(b)., s. 6. (11)(b), s. 6. (2) and s. 6. (7).
-written notification (WN) issued May 18, 2016 in report #2016_251512_0005 related to s. 6. (1)(c).

(672)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 26th day of February, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DIANE BROWN

Service Area Office /
Bureau régional de services : Central East Service Area Office