Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 30, 2015	2015_343585_0006	H-002016-15	Resident Quality Inspection

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD SUITE 205 TORONTO ON M6A 1J6

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

WELLINGTON PARK CARE CENTRE
802 HAGER AVENUE BURLINGTON ON L7S 1X2

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

LEAH CURLE (585), CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 18, 19, 20, 23, 24, 25, 26, and 27, 2015

Four complaint inspections H-001006-14, H-001098-14, H-001201-14, and H-001354-14, two Critical Incident System inspections H-000585-14 and H-000629-14, and one follow-up inspection H-000645-14 ~~in reference to H-000328-14~~ LV ink 383 were conducted concurrently during this Resident Quality Inspection (RQI) and are included in this inspection report. error LV Mar 12/15

During the course of the inspection, the inspector(s) spoke with residents, families, registered nursing staff, unregulated nursing staff, dietary aides, a physician, the Registered Dietitian, Food Service Manager, Director of Care, Resident Assessment Instrument (RAI) Coordinator, Admissions Coordinator, Staffing Coordinator, Social Services Coordinator, Environmental Services Manager, Maintenance Manager, and the Administrator.

During the course of the inspection the inspectors toured the home, observed the provision of care and services, and reviewed relevant documents including but not limited to: clinical health records, meeting minutes, policies/procedures, complaint logs, maintenance logs, dietary/food service documents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
21 WN(s)
14 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care set out (a) the planned care for the resident.

A) Resident #011 was at high nutrition risk, as identified in their plan of care. The resident reported they liked to eat in the dining room, however when they found it too loud, they preferred to eat in their own room, as the noise negatively impacted their appetite. The resident also reported they preferred to eat in their room at supper.

During a lunch meal service in February 2015, the resident was observed in the dining

room, appearing distressed and verbalizing that they were unhappy with noises in the dining room. The resident informed a personal support worker (PSW) that they wanted to go back to their room, stating they could not eat due to the noise.

Review of the resident's written plan of care revealed no indication of having the resident eat in their room as a strategy to optimize the resident's food intake. A progress note from the Registered Dietitian (RD) in January 2015 reported the resident was being provided supper in their room to maximize intake.

Multiple PSWs reported that the resident would eat in their room if the dining room was too loud, and it was common for the resident to eat in their room at supper. One PSW reported this approach assisted the resident in focusing on eating. This was confirmed by registered nursing staff, and the Registered Dietitian. Registered nursing staff, PSW's, and the RD all confirmed this intervention was not documented in the resident's written plan of care. (585)

B) Resident #010 sustained a fall in January 2015. The day after the fall, the Physiotherapist completed a post fall assessment, and advised that staff were to monitor the resident and place a bed alarm if needed. Nursing progress notes following the physiotherapist's assessment indicated that the alarm was in use. A PSW interviewed confirmed that the resident continued to use the alarm at night. A review of the plan of care did not include the planned care for the resident, specifically the use of the alarm, as confirmed during an interview with registered staff. (168) [s. 6. (1) (a)]

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

A) Resident #002 was noted to have a history of unwitnessed falls. An incident note following a fall and post falls assessment, both completed in February 2015, identified that the resident was at risk for falls, and had a personal alarm for safety, which the resident had removed. The electronic Treatment Administration Record (eTAR), included shift documentation for registered staff to ensure that the personal alarm was in place when the resident was in bed. Review of the clinical health record with registered staff confirmed that the eTARS did not identify the resident also required the personal alarm when resident was in their chair, nor was the the personal alarm included in the plan of care available to direct care staff (including the written care plan, kardex, or electronic Point of Care (POC)). Interview with registered and direct care staff confirmed that the resident required a personal alarm when in bed and chair for safety. Staff also stated that

the resident disliked the alarm and often removed or hid it, in which case, they would have to re-apply the alarm.

The written plan of care did not set out clear directions to registered staff as to when the resident required the alarm, and did not set out any direction to direct care staff that the resident required a personal alarm and often disconnected it. (528)

B) Resident #004 was identified as having poor food intake at meals, as noted in a RD assessment in January 2015. At this time, the RD initiated a therapeutic nutrition intervention to be provided three times a day during the home's standard medication pass, which was before each meal. Following the initiation of this intervention, a progress note in late January 2015 indicated the resident's family believed the administration of the intervention before meals may have contributed to the resident's poor food intake. The action plan from this note stated the intervention would be provided after meals.

In February 2015, the resident was noted to have a significant weight loss in one month. On February 24, 2015, the written plan of care indicated that the nutrition intervention was to be provided three times a day, but did not specify to be provided after meals. On this day, the resident was not observed to receive intervention after the lunch meal. Registered nursing staff who administered the intervention reported the resident frequently refused meals, that they administered the intervention before the meal, and confirmed they were unaware of the family's request for it to be provided after the meal. A RD progress note on February 24, 2015 also stated the resident had refused 30 of the last 38 meals, but was accepting the therapeutic nutrition intervention well. The RD and registered nursing staff confirmed the family's request was not documented in the written plan of care.

The written plan of care did not set out clear direction to staff and others who provided direct care to the resident with strategies to promote the resident's food intake to address their significant weight loss. (585)

C) Resident #011's written plan of care that outlined how PSWs were to position the resident while toileting. PSWs reported that the resident was toileted in a manner different to what was indicated in the resident's written plan of care. The Resident Assessment Instrument (RAI) Coordinator and PSWs confirmed there was no clear direction to staff on how the resident was toileted for continence and bowel care. (581) [s. 6. (1) (c)]

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

A) Resident #001's plan of care indicated they used one bed rail for mobility and transfers. From April 2014 to present, the Minimum Data Set (MDS) quarterly assessments, Section P. Devices and Restraint, coded the resident as not using "Other types of side rails (eg., half rail, 1 side)." Interview with the registered staff confirmed that the resident used one side rail daily for transfers as outlined in the written care plan. Interview with the RAI coordinator confirmed that the MDS quarterly assessments were not consistent with the written plan of care. (528)

B) Resident #023 demonstrated responsive behaviours. The MDS assessment completed in June 2014, identified that the resident demonstrated one behavioural symptom during a specified time period, which was easily altered. The MDS assessment and the Resident Assessment Protocol (RAP) completed in September 2014, identified that the resident demonstrated three behavioural symptoms which were easily altered, and that their Agitated Behaviour Scale (ABS) score increased from 0 to 2. This assessment also noted there was no change in behavioral symptoms in the past 90 days. Registered staff confirmed that the assessment completed in September 2014 was not consistent with the previous assessment when it noted there was no change in behavioural symptoms, and that the change in behaviour should have been coded as deteriorated. (581)

C) Resident #011 demonstrated mood patterns. A review of the MDS assessment completed in April 2014 identified that the resident had five mood indicators which were easily altered. The MDS assessment completed in June 2014, indicated that the resident demonstrated twelve mood indicators and that the mood indicators were not easily altered. This assessment also noted that there was no change in the resident's mood status in the past 90 days. Interview with registered staff confirmed that the assessment completed in June 2014 was not consistent with the previous assessment when it noted that there was no change in status, and that the change in mood should have been coded as deteriorated. (581)

D) Resident #022 was known to demonstrate responsive behaviours, which resulted in medication changes in November 2014, December 2014, and January 2015. The resident had a responsive behaviour assessment completed in October 2014, which identified the resident at a green threat level, and in January 2015, which identified red

as the threat level (higher risk).

i) A review of the MDS assessment completed in October 2014, for mood and behaviours patterns was compared with the assessment completed in January 2015. Both of these assessments were coded identically for the resident's indicators of depression, anxiety, sad and mood. These assessments also noted that the resident's mood persistence was easily altered and that the change in mood was an improvement, when compared to the resident's status 90 days prior. Interview with the RAI Coordinator confirmed that the coding completed on in January 2015, assessment for change in mood was not consistent with the assessment completed in October 2014, as there were no changes in the indicators of depression, anxiety, sad and mood, despite the fact that it was coded as an improvement.
ii) A review of the Resident Assessment Protocol (RAP) completed in January 2015, noted to include basic information about the reason for the RAP; however, was not a comprehensive assessment of the resident during the prior 90 days. This assessment did not include information regarding medication changes made during the 90 days prior nor the effectiveness of the interventions. Interview with the RAI Coordinator confirmed that the RAP did not complement with other assessments by the care team, including in the progress notes, physician's orders and point of care documentation. (168) [s. 6. (4) (a)]

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

A) In February 2015, resident #040 had a witnessed fall in the dining room, and activity staff was present. The plan of care identified that the resident was at risk for falls and interventions, included but were not limited to, ensuring the resident had the proper non-slip foot wear present. Review of the fall incident note identified that the resident was wearing socks at the time of the fall and slid. Interview with activity staff confirmed that the resident was not wearing non-slip footwear as outlined in the plan of care. The care set out in the plan of care was not provided to the resident as specified in the plan, related to non-slip footwear. (528)

B) Resident #011, who was identified at high nutritional risk, had a plan of care to receive a nutritional supplement three times a day during medication pass. Electronic medication administration record (eMAR) on February 18, 2015, at 1200 and 1600 hours, and February 19, 2015, at 0800 and 1200 hours revealed the resident did not receive the supplement, with reason coded "10=Drug Not Available". Interview with Registered nursing staff revealed the home did not have the supplement available on the floor to

provide it, and the resident did not receive the care set out in their plan of care. (585) [s. 6. (7)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised when, (b) the resident's care needs changed.

A) Resident #001's written plan of care indicated they were extensive assistance of two for personal hygiene which included mouth and oral care. Interviews with PSWs and review of the MDS assessment in December 2014, revealed the resident was extensive assistance with one staff. The RAI Coordinator confirmed that the plan of care was not reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

6. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (c) care set out in the plan has not been effective.

A) Resident #002 had a weight goal set in their plan of care in April 2014. The resident's weights from May 2014 to February 2015 were reviewed and revealed that weights were consistently below the goal identified in the plan of care. The RD confirmed the plan of care was not reviewed and revised when the care set out in the plan has not been effective in reaching the goal. (585)

B) Resident #011 had a weight goal set in their plan of care in June 2014. The resident's weights were reviewed and revealed they were under the goal in August 2014, and continued remain below and decline through to February 2015.

i) In October 2014, the resident's weight was below their goal weight. At this time, the RD indicated in a progress note, a new goal for weight maintenance, however no change was noted in the plan of care.
ii) In November 2014, the resident's weight was below their goal weight. At this time, the RD indicated in a progress note a new goal for no further weight loss, however no change was noted in the plan of care.
Subsequent months following, through to February 2015, the plan of care goal continued to state a weight goal from June 2014. The RD confirmed the goal was not effective or realistic for the resident, and plan was not reviewed and revised when the care set out in the plan was not effective for maintaining this goal. (585) [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that there is a written plan of care for each resident that sets out the planned care for the resident and clear directions to staff and others who provide direct care to the resident, that care set out in the plan of care is provided to each resident as specified in the plan, residents are reassessed and their plan of care reviewed and revised at least every six months and at any other time when a their care needs change and when care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The home did not fully recognize the resident #011's individuality and respect the resident's dignity when the resident was transferred within the home in 2014.

i) In 2014, resident #011 was transferred to a different home area due to care needs. Review of the plan of care identified that the resident made their own care decisions and was made aware of the home's decision two days prior to the move, at which time, it was documented that the resident was sad, concerned, and resisted the room change.
ii) The resident was moved despite their voiced concerns, and in an interview with the resident in February 2015, it was identified that the concerns had still not been resolved, as the resident remained unhappy on the new home area.
iii) Interview with multiple disciplines (including but not limited to, registered staff, activity

staff, Social Services Coordinator, Administrator, Director of Care (DOC), and the Physician) confirmed that the resident continued to express unhappiness with the room change and requests to move back to previous home area.
iv) In an interview held with the Administrator on February 27, 2015, it was identified that the home considered a room change as "a last resort". The Administrator stated that due to the resident's behaviours, they were moved to the new home area. In the same interview, the Administrator also outlined the following interventions would be trialed if a resident's family/Power of Attorney(POA)/Substitute Decision Maker (SDM) refused a room change: care conference with the team and family, education, evaluate staffing assignment changes, refer to Behavioural Supports Ontario (BSO) to address behaviours, trial a private care service for additional resident support; and they confirmed that the interventions were not trialed prior to resident #011's move to a new home area, despite their refusal.
v) The home's policy "Admission, Transfer and Discharges: RCS B-20", last revised July 2013, indicated that transfers can be arranged based on the wishes of a resident/family and/or a change in the level of care of the resident. The resident is to be transferred between the home areas after a full assessment by the interdisciplinary team with input from resident and family. An interview with the Administrator on February 27, 2015, confirmed that an assessment was not completed with input from the resident.
vi) Interviews with a full time registered staff and a personal support worker who regularly cared for the resident prior to the transfer indicated they were not part of the team decision to move the resident to the new home area.
vii) During the course of the inspection, resident #011 communicated to inspectors that since they did not have any family, there was no one to speak on their behalf. In September 2014, on behalf of the resident, an email was submitted to the Admission Coordinator by a private service agency, including an evaluation of services involving the resident and the resident's feeling of sadness and helplessness related to the room change. Interview with the Admissions Coordinator confirmed they received the email and met with the resident, however, there was no documentation to support the follow up.

The home did not follow their own policy for admission, transfer, and discharges when they failed to complete an assessment of resident #011 with the interdisciplinary team and with input from the resident. In addition, the process in which the home identified was in place if a resident's family/SDM/POA refused a room change was not followed for resident #011, who made their own care decisions. As a result, the resident reported to have continuous feelings unhappiness and helplessness for numerous months after the room and home area transfer. The home did not fully recognize the resident's

individuality and respect the resident's dignity when they resisted a transfer within the home in 2014. [s. 3. (1) 1.]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee to have or put in place any policy or procedure, that the policy, procedure was (b) complied with.

A) The home's policy, "Admission, Transfers and Discharges Policy - Subject: Internal Transfer - Index I.D: RCS B-20", last revised July 15, 2013, directed that a resident would be transferred between home areas after a full assessment by the interdisciplinary team with input from the resident and family.

In 2014, resident #011 was transferred to a different home area. No assessment was completed nor was the resident consulted or given input prior to the decision being made to transfer them. This was confirmed by the Administrator. (581)

B) The licensee failed to ensure that their policy related to obtaining and recording resident heights annually, was followed.

The home's policy, "Admission/Annual Height – Index I.D: RCS C-35", last revised July 15, 2013, stated that each resident's height was to be "determined and documented on admission and annually thereafter to determine the ideal body weight range".

Review of three residents clinical records indicated that heights were not taken annually.

i) Resident #002's most recent height was taken in May 2013.
ii) Resident #004's most recent height was taken in August 2012.
iii) Resident #011's most recent height was taken in May 2010.

Two registered nursing staff stated heights were only taken on admission. One registered nursing staff reported heights were to be taken annually. The Director of Care (DOC) confirmed heights were not determined and documented annually in the home. (585)

C) The licensee failed to ensure that their policy, "Height and Weight Monitoring – FNSCN076", effective February 5, 2012, in relation verifying significant changes in weights and ensuring scales are calibrated for accuracy, was followed.

i) The home's policy stated that "for any weight change of 5% or more from the previous month, the Unit Supervisor will verify by re-weighing the resident". Resident #011 was identified as having a significant change in weight of 5% or greater between June and July 2014, and between August and September 2014. The weight warning note for this resident did not indicate the resident was re-weighed for accuracy. A progress note from the Registered Dietitian and registered nursing staff confirmed the resident was not re-weighed to verify the change when there was a significant weight change from June to July 2014.

ii) The home's policy stated "scales must be calibrated semi-annually". Interview with PSWs and registered nursing staff in one of the home areas stated that the scale used to weigh residents before February 2015 did not always function properly, as staff would have to kick it to work. Review of the home's log for scale maintenance revealed calibration occurred July 16, 2013 and September 23, 2014. (585)

D) The home's procedure "Personal Hygiene and Grooming, RCS-D-05, last revised July 15, 2013", identified that "Resident's fingernails will be trimmed as part of their shower/bath routine. PSW's to clean nails daily or when required". According to a report from the home and staff statements, resident #020, who was dependent on staff for hygiene and grooming, was incontinent of bowels and demonstrated behaviours during a

night shift in May 2014. Staff working following day shift reported that the resident was not provided with nail care, cleaning when required, following their behaviours on the previous shift. Nail care was not provided as per the home's procedure until the day shift in May 2014. (168) [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that where the Act or this Regulation requires the licensee to have or put in place any policy or procedure, that the policy, procedure is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that doors leading to non-residential areas were kept closed and locked when not supervised by staff.

Two washrooms identified for staff use, located off a hallway used by staff, residents and visitors, were considered non-residential areas, as they did not contain a communication and response system, and signage on the door indicated it was to be locked at all times when not in use.

i) On February 18, 2015, at approximately 1015 hours, the staff washroom door on 3 East was noted to be closed; however, unattended and unlocked. The sign posted on the door noted the area as a staff washroom and identified to keep the door locked. (168)

ii) On February 23, 2015, the staff washroom on 3 East was unlocked and unsupervised. One resident was observed opening and entering the washroom with no staff present. No communication and response system was in the washroom. Two PSW's stated the door was to be locked at all times when not in use, as it was for staff use only. Registered nursing staff confirmed the door was to be locked as it was not for resident use, and no call-response system was located in the washroom. (585)

iii) On February 25, 2015, in the afternoon, the staff washroom on 1 East was unlocked and unsupervised. Staff reported the door was to be locked at all times when not in use, as it did not contain a call-response system. (585)

iv) On February 25, 2015, after supper meal service, the staff washroom on 1 East was unlocked and unsupervised. Staff reported the door was to be locked at all times when not in use. (585) [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that doors leading to non-residential areas are kept closed and locked when not supervised by staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

A) On two dates in February 2015, resident #001 was observed in bed with two bed rails in the raised position. The written plan of care and interview with registered staff identified that the resident only used one rail daily for mobility and transfers, however, interview with direct care staff indicated that the resident had two bed rails but did not use them for mobility. Review of the clinical health record did not include a nursing assessment of the bed rails to determine if the resident required one or two bed rails. Interview with registered staff confirmed that a formalized nursing assessment was not completed for bed rail use for resident #001. (528)

B) Resident #011's written plan of care indicated they required the use of two bed rails in the raised position for bed mobility and repositioning when in bed. Interviews with a PSW and RPN confirmed the resident had their bed rails raised when in bed. A review of the resident's written plan of care did not include an assessment of the bed rails being used. The RAI Coordinator and the registered staff confirmed that a formalized assessment was not completed for the use of bed rails in place. (581) [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a registered dietitian who is a member of the staff of the home (b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3).

A) Dietary referrals were sent to the RD in June 2014, as staff identified that resident #011 was experiencing constipation. The resident was not assessed by a RD until July 27, 2014. The RD confirmed that the resident was not assessed for constipation.

On July 27, 2014, the RD noted the resident had ongoing constipation, and they would discuss the use of intervention with the resident. Review of further progress notes and the plan of care did not indicate that the planned action to discuss this intervention with the resident occurred. This was confirmed by the RD.

B) In December 2014, progress notes indicated the resident #011 continued to experience constipation. On December 29, 2014, the RD completed a quarterly assessment and noted the resident's ongoing constipation, but included no action in the assessment to address constipation.

In January 2015, progress notes indicated the resident continued to experience constipation. A dietary referral was made on January 27, 2015, where nursing indicated the resident continued to have ongoing need for bowel protocol despite current interventions.

From January 27, 2015 to February 26, 2015, progress notes indicated the resident continued to experience constipation, and no assessment was made by the RD. No change in the resident's plan of care related to dietary interventions for their constipation was made since June 2014. [s. 26. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensure that a registered dietitian who is a member of the staff of the home, (b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3)., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a care conference of the interdisciplinary team providing a resident's care was held at least annually to discuss the plan of care and any other matters of importance to the resident.

In 2014, the physician requested a care conference be arranged in six to eight weeks for resident #011. Review of the plan of care indicated that an annual care conference was not held in 2014, with the resident, physician and the interdisciplinary team and this was confirmed by the Social Services Coordinator and physician. [s. 27. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that a care conference of the interdisciplinary team providing a resident's care is held at least annually to discuss the plan of care and any other matters of importance to the resident, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept relating to each annual program evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A) Interviews with the Administrator on February 27 and March 3, 2015, identified that the home was unable to produce a written record of annual evaluation of the Falls Prevention and Management Program in 2014. (528)

B) Documentation provided by Food Service Manager on March 3, 2015 revealed that the home had a written record of the dietary services and hydration program evaluation in 2014, however it did not include the specific date of the evaluation, the names of the persons who participated, and the date changes were implemented. This was confirmed by the Food Service Manager on March 6, 2015. [s. 30. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that a written record is kept relating to each annual program evaluation that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who exhibited a skin tear, was assessed by a Registered Dietitian.

A)Resident #011 was identified as having a new skin tear in February 2015. Review of clinical progress notes did not reveal a referral was made to the RD. On February 27, 2015, the RD confirmed no referral was made or assessment completed for the resident's skin tear. [s. 50. (2) (b) (iii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that a resident who exhibited a skin tear, is assessed by a Registered Dietitian, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

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

Findings/Faits saillants :

1. The licensee failed to ensure that there a written record relating to each evaluation of the responsive behaviour program that included date of the evaluation, names of the persons who participated, summary of the changes made, and, date that those changes were implemented.

Interviews with the Administrator on February 27, 2015 and March 3, 2015 confirmed that the home could not produce a written record of the annual evaluation of the Responsive Behaviour Program from 2014 or 2015. [s. 53. (3) (c)]

2. The licensee failed to ensure that the actions taken to meet the needs of the resident with responsive behaviours included assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

In February 2015, resident #024 was involved in two separate altercations with co-residents. Review of the resident's clinical health record included documentation in the progress notes describing both incidents, but did not include any interventions used or the resident's responses to interventions. Interview with registered staff who witnessed, responded to, and documented the incidents confirmed that the actions staff took in responding to the incidents and the resident's responses to those interventions were not documented. [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that there is a written record relating to each evaluation that included date of the evaluation, names of the persons who participated, summary of the changes made, and, date that those changes were implemented, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that resident #011 was assessed using an interdisciplinary approach, and that actions were taken and evaluated when they had a change of 5 per cent of body weight, or more, over one month.

The resident #011 experienced multiple occurrences of significant weight loss of 5 per cent, or more over one month, and 7.5 per cent, or more, over three months, to which there was no interdisciplinary assessment, actions taken, or evaluation of the actions taken.

i) The resident had significant weight loss of over one month from June to July 2014. Review of the clinical progress notes revealed that no assessment occurred by nursing staff, no referral was made to the RD, no assessment was conducted by the RD, and no changes were noted in the resident's written plan of care when the weight loss was identified. The resident was not assessed until late July 2014. This was confirmed by the RD.

ii) In late July 2014, the RD completed a quarterly assessment, noting the resident's weight loss between June and July 2014, and stated it 'seemed unlikely' as there was no reweigh, and 'will follow Aug. weight'.

Progress notes revealed the resident continued to experience weight loss in August and September 2014. On September 9, 2014, an additional significant weight loss occurred

over one month. Dietary referrals regarding the weight loss were made in August and September 2014 to the RD. There was no follow-up on the assessment from July 2014, or interdisciplinary assessment completed when the resident had significant weight loss identified in September 2014. The resident was assessed by the RD in late September 2014, where no action was taken in relation to the resident's weight loss from July 2014 or September 2014. This was confirmed by the RD.

iii) In September 2014, there was a multidisciplinary team meeting for the resident which included a review of their care plan and needs. The note stated a regular, full-time nurse from the resident's home area was at the meeting. There was no documentation regarding an assessment or action plan for the resident's significant weight loss.

iv) In November 2014, the resident had a significant weight loss over three months. A referral made to the RD. An RD assessment completed later in November 2014 revealed no action was taken to address the weight loss.

v) In December 2014, the resident's weight declined again in one month. In mid-December 2014, the RD initiated a therapeutic nutrition intervention to address the resident's weight loss. No other intervention was noted in the written plan of care by staff to address the resident's significant weight loss until this time. The RD confirmed no action was taken to address the resident's significant weight loss from July 2014 until December 2014.

vi) Registered nursing staff on the resident's home area reported that when a resident had 5 per cent or greater change in weight over one month, they were to re-weigh the resident. The resident's weight log was reviewed, and re-weighs were not noted for the times the resident had a significant change in weight in July and September 2014. As part of an interdisciplinary assessment, no action was taken to verify when the significant weight loss occurred. This was confirmed by registered staff.

vii) Regulated and unregulated staff on the resident's home area stated the tub room scale present during the above time frame did not always function properly, and staff would sometimes need to kick it to work. No staff were able to confirm that they reported the issue with the scale to maintenance. Maintenance logs were reviewed from June 2014 onward, which included one request from the RD in October 2014, questioning the accuracy of the home area's scale. Interdisciplinary action was not taken by staff to ensure the tools used to assess the resident's weight were accurate, and in good working order. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: 1. A change of 5 per cent of body weight, or more, over one month. 2. A change of 7.5 per cent of body weight, or more, over three months. 3. A change of 10 per cent of body weight, or more, over 6 months. 4. Any other weight change that compromises the resident's health status, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system provided for at a minimum, a three-day supply of nutritional supplements.

Registered nursing staff in one of the home areas reported that a therapeutic nutrition supplement was not available to provide to the residents who required it on February 18, 2015 during the medication pass at 1200 and 1600 hours, and on February 19, 2015 at 0800 and 1200 hours during the medication pass. The Food Service Manager confirmed the home did not maintain a three day supply of the nutritional supplement. [s. 72. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the food production system provides for at a minimum, a three-day supply of nutritional supplements, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the licensee sought out the advice of the Family Council in developing and carrying out the satisfaction survey.

Review of the Family Council minutes from 2014 did not include any documentation indicating that the licensee sought out the advice in developing and carrying out the annual satisfaction survey. On February 25, 2015, the Family Council President was interviewed and could not recall if the home had sought out the advice of the Council in 2014. Interview with the Social Services Coordinator the same day confirmed that a review of the Satisfaction Survey was completed in August 2013 and not in 2014. [s. 85. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the licensee seeks out the advice of the Family Council in developing and carrying out the satisfaction survey, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record is kept in the home that included,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

In 2014, resident #011 was transferred to a different home area due to care needs, as reported by administrative staff. Review of the plan of care identified that the resident made their own care decisions and was made aware of the home's decision two days prior to the move, at which time, it was documented that the resident was sad, concerned, and refused the room change. The resident was moved despite their voiced concerns, and in an interview with the resident in February 2015, it was identified that the concerns had still not been resolved, as the resident remained unhappy on the new home area.

i) For numerous months in 2014, progress notes included documentation from multiple disciplines (including but not limited to, registered staff, activity staff, Admissions Coordinator, Administrator, and, Registered Dietitian) noting the resident's concerns, complaints, and unhappiness with the room change; however, did not include any action taken to resolve the complaint.
ii) In 2014, the physician requested a care conference resident, which the Social Services Coordinator, who organized the home's care conferences, confirmed never occurred.
iii) In 2014, the physician documented the resident's ongoing complaints of unhappiness on the new floor and recommended a trial placement off the floor. A response from the Administrator, documented in the resident's progress notes identified that due to care needs the resident was appropriately placed, however, did not include any discussion with the resident.
iv) In 2014, staff from a private care service submitted an evaluation of services for resident #011. The evaluation included written statements from the staff on behalf of resident, outlining complaints of unhappiness and helplessness as a result of the move. No follow up was documented. Interview with Admission Coordinator on March 3, 2015, confirmed they received the concerns and followed up with the resident but it was not documented.
v)From February 25 to 27, 2015, interviews with registered and direct care staff confirmed that since the resident's room change in June to present time, there had been consistent ongoing complaints of unhappiness with the room change and the resident continued to request to move off the home area.
vi) Review of the complaints log from 2014 and 2015, did not include resident #011's ongoing complaints.
vii) On February 27, 2015, an interview was held with both the Social Services Coordinator and Administrator. The Social Services Coordinator confirmed that a final resolution was not reached and would not be reached until the resident was moved off

the home area. The Social Services Coordinator, who maintained the home's concern and complaint log, confirmed that the resident's complaints were not documented in the home's complaints log because it was an ongoing issue. The Social Services Coordinator indicated that they spoke with the resident related to concerns in 2014 but confirmed they did not document the meetings. The Administrator and Social Services Coordinator indicated that support had been given to the resident related to ongoing concerns of moving to a new home area but the plan of care did not identify any actions taken to attempt to resolve the resident's concerns.
vii) Interviews with the Administrator and Director of Care (DOC), confirmed that the home failed to document the residents consistent complaints with the change in room and home area. It was confirmed that these concerns were ongoing. The home was unable to provide any additional details within relation to actions taken to resolve the resident's concerns. The Administrator and DOC stated that they had met with the resident numerous times within relation to the resident's ongoing complaints but could not provide documentation to support those meetings. [s. 101. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensure that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.

WN #15: 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 failed to ensure that all areas where drugs were stored were kept locked at all times, when not in use.

A) On February 23, 3015 before dinner service, the RPN on 3 East home area was observed administering medications. At approximately 1700 hours, the RPN left the medication cart to administer medications in the dining room. The cart was left unlocked in the nursing station, and the nursing station door was unlocked and open. At that time, residents who were cognitively impaired were noted wandering in and out of the dining room beside the nursing station. The inspector was able to enter the nursing station and open medication cart drawers without the RPN being aware. When the RPN returned, they confirmed that the cart was to be locked at all times when unattended.

B) On February 27, 2015, during lunch service on 3 East, the nursing station and medication cart was noted to be open and unlocked. The RPN was observed in the dining room and residents were wandering around the nursing station. The inspector was able to open and close medication cart drawers with the nursing staff unaware. Interview with the RPN confirmed the medication cart was to be locked when the RPN stepped away from the cart and was immediately locked. [s. 130. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a a written complaint received concerning the care of a resident or the operation of the long-term care home is immediately forwarded it to the Director.

A) In 2014, resident #011 complained to the home regarding a room transfer to new home area. Several months following the move, a written evaluation from a private care service was submitted to the Admissions Coordinator. The evaluation included written statements on behalf of the resident, indicating that the resident was unhappy with with transfer to the new home area.

i) the Admissions Coordinator documented receipt of the written concerns in September 2014.
ii) Interview with the Admissions Coordinator on March 3, 2015, confirmed that they followed up with the resident after they reviewed the evaluation.
iii) Review of the plan of care did not include any documentation of the follow up conversation with the resident.
iv) Interviews with the Admissions Coordinator and the Administrator on March 3, 2015, confirmed that the written complaints from the private care service staff on behalf of resident #011 were not forwarded to the Director.

The written statements in the evaluations were not forwarded to the Administrator or the Director. [s. 22. (1)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of daily living included in a resident's plan of care only if the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

A) On February 18 and 23, 2015, resident #001 was observed in bed with two bed rails in the raised position. The written plan of care indicated that the resident required one bed rail in the raised position for mobility and transfers. Review of the clinical health record did not include consent for the bed rails by the resident's Substitute Decision Maker (SDM). Interview with direct care and registered staff confirmed that the resident used bed rails daily. Registered staff confirmed that consent was not obtained for any bed rail use. [s. 33. (4) 4.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who cannot brush their own teeth received physical assistance or cueing.

Resident #009's plan of care indicated that they required assistance of one staff with oral hygiene twice daily. Interview with the resident identified that staff did not always provide assistance after supper and sometimes had difficulty performing oral care tasks on their own. After supper on an unspecified date in February 2015, the resident was observed performing oral care on their own. The inspector interviewed the PSW caring for the resident who reported that no assistance was provided as the resident could do it. The resident was not provided with physical assistance with oral care in the evening, as outlined in the plan of care. [s. 34. (1) (b)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) On February 18, 20, 23, and 24, 2015, resident #007's wheelchair was observed to have dried food stains on the chair seat and metal frame. The home's Nursing Weekly Cleaning Schedule identified that the resident's wheelchair was to be cleaned on February 19, 2015. In an interview with a PSW, it was confirmed that the resident used the wheelchair daily. The PSW agreed that the wheelchair seat and metal frame were unclean and did not appear to be cleaned as scheduled. [s. 87. (2) (b)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure that an analysis of the restraining of residents by use of a physical device was undertaken on a monthly basis.

Review of the home's annual evaluation for Restraints and PASD program for 2014, indicated that the restraining of residents by a physical device was not analyzed monthly. This was confirmed by the Administrator. [s. 113. (a)]

2. The licensee failed to ensure that changes or improvements identified in the annual evaluation were implemented promptly.

The Administrator provided a written copy of the annual evaluation for the Restraints and PASD program for 2014. The document provided did not include the date the changes or improvements were implemented. The Administrator confirmed that changes or improvements that were identified in the annual evaluation had not been implemented to date. [s. 113. (d)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that for the resident taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

After a fall in August 2014, resident #031 was started on a new analgesic to be administered routinely and as required (PRN) for pain. The dosages were then increased by the physician the following day. The home's "Pain Management Policy, RCS-G-60", last revised July 2013, directed staff to evaluate the effectiveness of new pain medications or adjustments to doses on the Pain Flow Sheet as well as in the resident's electronic progress notes. Review of the plan of care did not include a Pain Flow Sheet or progress notes following the new pain medication order or increase in dosage for the resident. Interview with registered staff confirmed that the monitoring of the resident's responses to the new ordered analgesia was not documented as outlined in the policy. [s. 134. (a)]

Issued on this 17th day of April, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LEAH CURLE (585), CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), LISA VINK (168)
Inspection No. / No de l'inspection :	2015_343585_0006
Log No. / Registre no:	H-002016-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 30, 2015
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6
LTC Home / Foyer de SLD :	WELLINGTON PARK CARE CENTRE 802 HAGER AVENUE, BURLINGTON, ON, L7S-1X2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Charlotte Nevills

To RYKKA CARE CENTRES LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_188168_0009, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.
The plan is to include, but is not limited to the development and implementation of:

a) a training program for all staff involved in assessments of residents to ensure they are able to effectively collaborate with each other in assessments, and ensure assessments are integrated, consistent with and complement each other,

b) protocols and/or procedures for staff that they must use to conduct collaborative assessments, ensure assessments are integrated, and that are consistent with and complement each other; and

c) processes and schedules for monitoring staff's performance in ensuring that those involved in the different aspects of care of the resident are collaborating with each other in the assessment of the resident in a manner that is accurate and timely, and that assessments are integrated, consistent with, and complement each other.

The plan is to be submitted on or before April 14, 2015 to Leah Curle at leah.curle@ontario.ca

Grounds / Motifs :

1. Previously identified as non-compliant in April 2014, as a CO. (581)

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

A) Resident #023 demonstrated responsive behaviours. The MDS assessment completed in June 2014, identified that the resident demonstrated one behavioural symptom during a specified time period, which was easily altered. The MDS assessment and the Resident Assessment Protocol (RAP) completed in September 2014, identified that the resident demonstrated three behavioural symptoms which were easily altered, and that their Agitated Behaviour Scale

(ABS) score increased from 0 to 2. This assessment also noted there was no change in behavioral symptoms in the past 90 days. Registered staff confirmed that the assessment completed in September 2014 was not consistent with the previous assessment when it noted there was no change in behavioural symptoms, and that the change in behaviour should have been coded as deteriorated. (581)

B) Resident #011 demonstrated mood patterns. A review of the MDS assessment completed in April 2014 identified that the resident had five mood indicators which were easily altered. The MDS assessment completed in June 2014, indicated that the resident demonstrated twelve mood indicators and that the mood indicators were not easily altered. This assessment also noted that there was no change in the resident's mood status in the past 90 days. Interview with registered staff confirmed that the assessment completed in June 2014 was not consistent with the previous assessment when it noted that there was no change in status, and that the change in mood should have been coded as deteriorated. (581)

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

A) Resident #022 was known to demonstrate responsive behaviours, which resulted in medication changes in November 2014, December 2014, and January 2015. The resident had a responsive behaviour assessment completed in October 2014, which identified the resident at a green threat level, and in January 2015, which identified red as the threat level (higher risk).

i) A review of the MDS assessment completed in October 2014, for mood and behaviours patterns was compared with the assessment completed in January 2015. Both of these assessments were coded identically for the resident's indicators of depression, anxiety, sad and mood. These assessments also noted that the resident's mood persistence was easily altered and that the change in mood was an improvement, when compared to the resident's status 90 days prior. Interview with the RAI Coordinator confirmed that the coding completed on in January 2015, assessment for change in mood was not consistent with the assessment completed in October 2014, as there were no changes in the indicators of depression, anxiety, sad and mood, despite the fact that it was

coded as an improvement.
ii) A review of the Resident Assessment Protocol (RAP) completed in January 2015, noted to include basic information about the reason for the RAP; however, was not a comprehensive assessment of the resident during the prior 90 days. This assessment did not include information regarding medication changes made during the 90 days prior nor the effectiveness of the interventions. Interview with the RAI Coordinator confirmed that the RAP did not complement with other assessments by the care team, including in the progress notes, physician's orders and point of care documentation. (168)

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

A) Resident #001's plan of care indicated they used one bed rail for mobility and transfers. From April 2014 to present, the Minimum Data Set (MDS) quarterly assessments, Section P. Devices and Restraint, coded the resident as not using "Other types of side rails (eg., half rail, 1 side)." Interview with the registered staff confirmed that the resident used one side rail daily for transfers as outlined in the written care plan. Interview with the RAI coordinator confirmed that the MDS quarterly assessments were not consistent with the written plan of care. (528)

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

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

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

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

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

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

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

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

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

i. the Residents' Council,

ii. the Family Council,

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

iv. staff members,

v. government officials,

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

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

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

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

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

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

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

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

Order / Ordre :

The licensee shall:
1) Ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2) Ensure that resident #011 is treated with courtesy and respect in a way that fully recognizes their individuality and respects their dignity in regards to the decision of their transfer of room to another home area, taking into account any assessments and reassessments required, and include input from both the resident and their interdisciplinary care team.

Grounds / Motifs :

1. The home did not fully recognize the resident #011's individuality and respect the resident's dignity when the resident was transferred within the home in 2014.

i) In 2014, resident #011 was transferred to a different home area due to care needs. Review of the plan of care identified that the resident made their own care decisions and was made aware of the home's decision two days prior to the move, at which time, it was documented that the resident was sad, concerned, and resisted the room change.
ii) The resident was moved despite their voiced concerns, and in an interview with the resident in February 2015, it was identified that the concerns had still not been resolved, as the resident remained unhappy on the new home area.
iii) Interview with multiple disciplines (including but not limited to, registered staff,

activity staff, Social Services Coordinator, Administrator, Director of Care (DOC), and the Physician) confirmed that the resident continued to express unhappiness with the room change and requests to move back to previous home area.
iv) In an interview held with the Administrator on February 27, 2015, it was identified that the home considered a room change as "a last resort". The Administrator stated that due to the resident's behaviours, they were moved to the new home area. In the same interview, the Administrator also outlined the following interventions would be trialed if a resident's family/Power of Attorney (POA)/Substitute Decision Maker (SDM) refused a room change: care conference with the team and family, education, evaluate staffing assignment changes, refer to Behavioural Supports Ontario (BSO) to address behaviours, trial a private care service for additional resident support; and they confirmed that the interventions were not trialed prior to resident #011's move to a new home area, despite their refusal.
v) The home's policy "Admission, Transfer and Discharges: RCS B-20", last revised July 2013, indicated that transfers can be arranged based on the wishes of a resident/family and/or a change in the level of care of the resident. The resident is to be transferred between the home areas after a full assessment by the interdisciplinary team with input from resident and family. An interview with the Administrator on February 27, 2015, confirmed that an assessment was not completed with input from the resident.
vi) Interviews with full time a registered staff and a personal support worker who regularly cared for the resident prior to the transfer indicated they were not part of the team decision to move the resident to the new home area.
vii) During the course of the inspection, resident #011 communicated to inspectors that since they did not have any family, there was no one to speak on their behalf. In September 2014, on behalf of the resident, an email was submitted to the Admission Coordinator by a private service agency, including an evaluation of services involving the resident and the resident's feeling of sadness and helplessness related to the room change. Interview with the Admissions Coordinator confirmed they received the email and met with the resident, however, there was no documentation to support the follow up.

The home did not follow their own policy for Admission, Transfer, and Discharges when they failed to complete an assessment of resident #011 with the interdisciplinary team and with input from the resident. In addition, the process in which the home identified was in place if a resident's family/SDM/POA refused a room change was not followed for resident #011,

who made their own care decisions. As a result, the resident reported to have continuous feelings unhappiness and helplessness for numerous months after the room and home area transfer. The home did not fully recognize the resident's individuality and respect the resident's dignity when they resisted a transfer within the home in 2014. [s. 3. (1) 1.]
(528)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 30th day of March, 2015

Signature of Inspector /
Signature de l'inspecteur :

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

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