Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Nov 03, 2015;	2015_348143_0026 (A1)	O-002281-15	Resident Quality Inspection

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

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

CARESSANT CARE MARMORA
58 BURSTHALL STREET P.O. BOX 429 MARMORA ON K0K 2M0

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

AMBER MOASE (541) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance date for CO #001 was amended at the request of the licensee to continue to work on a permanent solution for 24/7 RN coverage.

Issued on this 3 day of November 2015 (A1)

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

Original report signed by the inspector.

Ontario

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

AMBER MOASE (541) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): July 6th to 10th, and July 13th to 15th, 2015.

The following were concurrently completed during this Resident Quality Inspection: Logs

#O-001132-14, O-001511-15, O-002392-15, and O-002441-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, Registered Nurses, Registered Practical Nurses, Personal Support Workers, housekeeping staff, laundry staff, family members and residents.

During the course of the inspection, the inspectors: conducted a walking tour of the home, observed resident dining, medication administration practices and resident care, reviewed resident and family council meeting minutes, resident health care records and applicable

policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

- **8 WN(s)**
- **5 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Registered Nurse is on duty and present at all times.
Caressant Care Marmora is an 84 bed Long Term Care Home.
A review of Caressant Care Marmora Registered Staffing Schedule for the period June 8 2015 to July 6th, 2015 indicated the following:
On June 8th, 9th, 10th and 11th the home did not have a RN present in the home for the evening shift (1400 hours to 2200 hours)
On June 16th the home did not have a RN from 2200-0600 hours.
On June 20th the home did not have a RN from 1400 to 0600 hours (2 shifts)
On June 21 and 22nd the home did not have a RN from 1400 hours to 2200 hours
June 23rd and 24th the home did not have a RN from 2200 hours to 0600 hours
On June 28th the home did not have a RN from 1400 hours to 2200 hours.
On July 1st the home did not have a RN from 2200 hours to 0600 hours
On July 4th the home did not have a RN from 1400 hours to 2200 hours.
On July 6th the home did not have a RN from 1400 hours to 2200 hours.
Ontario Regulation 79/10 section 45.(2) indicates that "emergency" means an unforeseen situation of a serious nature that prevents a Registered Nurse from getting to the long-term care home. The thirteen shifts were not identified as a case of an emergency where the exception as per Ontario Regulation 45.(2).ii would apply.
The thirteen shifts were reviewed and discussed with the Administrator who confirmed that an emergency did not exist where the exception as per Ontario Regulation 45. (2).ii would apply. The Administrator reported to the Inspector that a Registered Practical Nurse was scheduled when a RN was not on duty and present in the home.
The Director of Nursing reported to the Inspector that the home currently has a full time RN on maternity leave. The Director of Nursing reporting that the home had advertised the vacant position but was not successful in recruiting a RN for a temporary position.
On a specified date Resident #11 successfully exited the building despite wearing a functioning wanderguard bracelet. The resident sustained a fall during the elopement and sustained minor injuries. During this period of time no RN was on duty and present in the home. [s. 8. (3)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: 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 has failed to ensure that written policies and protocols related to the medication management system are complied with.

The following non compliance is in respect of Log O-002392-15:

Ontario Regulation 79\10 section 114 (2) identifies the following:
The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Medical Pharmacies Policy #4-5 Nurse Ordering Medications from Pharmacy by Phone date 01/14 indicates the following:
Policy
Telephone orders for new medication are accepted by pharmacy on an emergency basis if phoned in by a nurse.

Procedure
1. Confirm that you are speaking with a pharmacist or a regulated pharmacy technician.
2. Provide the following information: home name, unit, resident's first and last names, any medication allergies, medication name & strength, dosage, route, full directions, Prescriber's name and initial, name of nurse phoning order.
4. Write "phoned in" on order and communicate a copy as soon as possible to pharmacy.

On a specified date Resident #43 was transferred to hospital, received treatment and was transferred back to the home. Hospital discharge orders indicated that Resident #43 be ordered a specific type of medication. S113 (RPN) processed the orders and faxed them to an attending physician. The attending physician fax number indicated a busy response and S113 left a voice message for the attending physician to call the home. Later that day, S114 discussed Resident #43's hospital discharge orders with a second attending physician and received a telephone order authorizing the medication.
S114 processed the orders and faxed them to Medical Pharmacies. A review of this order indicated that S114 did not indicate on the order form that she\he had taken a telephone order and failed to sign indicating that she\he had taken the telephone order. S114 was interviewed on July 15th, 2015 by the inspector and reviewed the physician order form. S114 was questioned if the form required a second nurse to process the order and date and sign and S114 indicated yes. S114 reported that orders are double checked to ensure that they are processed and that this is generally completed by RN working the night shift. A review of the order indicated that a second nurse had not processed the order. Three days later Resident #43 had not received the prescribed medication and was transferred back to hospital.
The home failed to ensure that the medication policy was complied with by not following the procedure when completing a telephone order. [s. 8. (1) (b)]

2. The following non compliance is related to log #0-001132-14:

Medical Pharmacies policy 3-6 The Medication Pass page 2 of 2 (date 01/14) procedure:
8. Administer medications and ensure that they are taken.
a. document on MAR in proper space for each medication administered or document by code if medication not given.
b. for range of dose medications, document actual amount administered.
c. document site of application or administration, if applicable.

10. Chart administration of PRN medications either on eMAR, the resident progress note, on an "individual PRN Administration Record", or on the reverse of the paper MAR, as per home policy.

On a specified date the home submitted a Critical Incident Report to the Ministry of Health and Long Term Care indicating that a staff member had failed to record delivery of narcotics as per the College of Nurses of Ontario medication administration standards.
Administrative staff completed an internal investigation and determined that S116 (Registered Practical Nurse) had failed to document the administration of controlled substances for 11 residents on 22 occasions over a span of approximately 8 weeks.
The Director of Nursing reported to the inspector that the home was not able to determine any negative outcomes for the residents. S116 received progressive discipline from the home and administrative staff reported the incident to the College of Nurses of Ontario.
The home failed to ensure that the medication policy was complied with by not following the procedure for documenting the administration of medications. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all registered staff are trained with respect to obtaining and transcribing verbal\phone orders and procedures related to obtaining medications, and completing the required documentation related to medication administration, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written staffing plan is in place for the nursing and personal support services program.
On July 14th, 2015 Inspector #143 met with both the Administrator and the Director of Care and requested a copy of the staffing plan. The Administrator and the Director of Care both reported to the inspector that the home does not have a written staffing plan in place. The Inspector was advised that the home has a schedule in place and that yearly the corporate office of Caressant Care reviews Ministry funding and provides a staffing mix based on funding. Administrator reported that she did not have a written record that demonstrated that the staffing plan had been evaluated annually. [s. 31. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a written staffing plan for the nursing and personal support services is in place, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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 has failed to comply with O. Regs 79/10, s. 53 (4) (b) whereby strategies have not been developed and implemented to respond to Resident #11's responsive behaviours.

The following non compliance is related to log #0-002441-15:

On a specified date Resident #11 eloped from the home despite wearing a functioning wanderguard bracelet. PSW S#111 and RPN S#115 were both interviewed and were working at the time of the elopement. Both stated they had not heard the wanderguard alarm and both stated the alarm can be difficult to hear if working in a resident room with the door closed or if working at the end of a hallway. The staff believed the resident may have exited the home when visitors were leaving. The DON was interviewed and stated that the wanderguard alarm is best heard in the area of the nursing desk and she has in the past contacted the company to increase the audibility of the alarm or to install speakers on the resident hallways, but the company has stated there is nothing that can be done.

Resident #11's health care record was reviewed and since the elopement Resident #11 has attempted to exit the building on two subsequent occasions. The resident's plan of care related to wandering and elopement was reviewed. The care plan, in effect at the time of this inspection, stated to monitor the wanderguard every shift, but there were no strategies or interventions identified to address the resident's ongoing exit seeking behaviour.

The DON stated the behaviour appeared to be unpredictable and that staff monitor the resident's whereabouts but that there was no specific identified time frames related to the monitoring. The Administrator stated the home does have access to the behavioural support team but to date of this inspection, they have not been consulted to assess Resident #11's responsive behaviours related to wandering/elopement.

There is identified risk associated with the resident eloping again given the evidence to support Resident #11 continues to exit seek and the unpredictability of the wanderguard bracelet in alerting staff of future elopements. [s. 53. (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 to ensure that strategies are in place and implemented related to residents at risk for elopement, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 87(2)(d) in that the procedures developed and implemented to address incidents of lingering offensive odours were not effective.

On July 9, 2015, Inspectors #602 and #143 noted a urine odour in the shared bathrooms of resident rooms. Inspector #197 visited these areas multiple times throughout the day on July 13, 14 and 15, 2015 and noted that the urine smell remained. On July 14, 2015, it was noted that bathroom had urine on the floor around the toilet from approximately 1000 hours to 1400 hours, at which time the Inspector reported the issue to the evening housekeeper, staff member S110. The floors in two other bathrooms were also noted to have dark stains around the toilet.

On July 13, 2015, housekeeping staff member #S106 was interviewed and stated that two rooms have a urine odour. She indicated that the Residents in these rooms will urinate on the floor and so she cleans these rooms first when she arrives in the morning. She said they try to clean up urine as soon as possible but feels the odour is now in the floor tiles. She said that they use air fresheners and a specific deodorizer, which help initially but the smell always returns. She stated that it is an ongoing issue in these two rooms.

On July 14, 2015, housekeeping staff member #S110 was interviewed and she stated she was unaware of any urine odours in the home

An interview was conducted with the Administrator and Director of Care on July 14, 2015 who stated that there is a plan to replace the floors in these bathrooms, but this has not been completed as of yet. [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are implemented in the management of offensive odours and if not effective that strategies are put into place, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents receive medications as prescribed.

The following non compliance is related to log #O-002392-15:

On a specified dateResident #43 was transferred back to Caressant Care Marmora from hospital. Resident #43 was ordered a specific type of medication. S113 (RPN) processed the orders and faxed them to an attending physician. The attending physician fax number indicated a busy response and S113 left a voice message for the attending physician to call the home. Later that day S114 (RPN) discussed Resident #43's hospital discharge orders with a second attending physician and received a telephone order authorizing the medication order.
S114 processed the orders and faxed them to Medical Pharmacies. A review of this order indicated that S114 did not indicate on the order form that she\he had taken a telephone order and failed to sign indicating that she\he had taken the telephone order. Medical Pharmacies did not process the order and the resident did not receive the medication as ordered. The resident did not receive the ordered medication for a three day period and was transferred back to hospital. A review of this medication incident indicated that the Pharmacy reported that a staff member called the home on June 26th, 2015 advising the home that the order could not be processed without a physicians signature. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that physician orders are processed and that residents receive medications as prescribed, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 15 (2) (c) in that the home was not maintained in a good state of repair.

During this inspection the Environmental Services Manager was not able to be interviewed. The Administrator provided inspectors with a preventative maintenance schedule.

Inspectors observed the following in Resident rooms July 6-9, 2015:

Rm 203 - black streak\mark on wall to left of window (143)

Rm 207 - vanity seal lifting/not in place, bathroom door and frame dented, scratched,

paint chipping (602)

Rm 208 - paint chips and dents in bathroom door, plastic edging lifting/not sealed with floor (602)

Rm 209 - caulking has lifted around sink in bathroom, plastic edging at floor lifting, chipping and dents in bathroom door and wall (602)

Rm 210 - door frame and door have paint chips and dents (602)

Rm 211 - dark stains on floor and in seams, paint chips/dents on doors and frames in bedroom and bathroom (602)

Rm 213 - paint chips/dents in bathroom door frame, caulking around bathroom floor and linoleum lifting, caulking at sink and at base of toilet coming off (602)

Rm 214 - bathroom door frame/door has paint chips and dents (602)

Rm 216 - door frame and bathroom door has paint chips and scratches/dents, plastic linoleum edging at bathroom floor beginning to lift in some places (602)

Rm 217 - edge of flooring between bathroom and bedroom floor coming up, caulking lifting at vanity and wall under paper towel dispenser (602)

Rm 221 - scarring on back of bathroom door (197)

Rms 222, 224, 225, 226, 227 - rusted toilet paper holder in bathrooms (197)

Rm 230 - bathroom door noted to be marked at bottom, bathroom interior door observed to have paint scratched\peeled off (143)

Rm 232 - paint chips and scratches on inner bathroom door, edge/seal between wall and baseboard not adhered in places (602)

Rm 233 - toilet paper holder rusted, brown staining/marks at edge between bathroom and bedroom flooring, paint peeling on lower wall in bathroom (602)

On July 21st, 2015 Inspector #143 reviewed the homes preventative maintenance schedule with the Administrator. The Administrator advised the inspector that repairs

in the home had been assessed as urgent requiring work to be done within 3 to 6 months and priority to be addressed by September 14, 2015. The Administrator indicated that repairs to rooms 203, 207, 211, 217, 222, 224, 225, 226, 227, 233 and room 232 were not assessed as being urgent and or priority. [s. 15. (2) (c)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 107 (1) 4. whereby the Director was not immediately notified of a missing resident who returned to the home with an injury.

The following non compliance is related to log #0-002441-15

On a specified date Resident #11 successfully exited the home despite wearing a functioning wanderguard bracelet. The resident was returned to the home after being seen by an off duty PSW on a nearby street. Upon the resident's return, they were assessed by the staff and noted to have injuries related to a fall sustained during the elopement.

The Administrator reported to Inspector #143 that S117 reported the missing resident to Director of Nursing prior to the end of her\his shift. At the time of the elopement the Administrator was acting as the on call RN (as the home did not have a RN present and on duty in the home). The Director of Nursing advised the Administrator of the incident approximately 12 hours following the elopement at which time Ministry of Health was notified. [s. 107. (1) 4.]

Issued on this 3 day of November 2015 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : AMBER MOASE (541) - (A1)

Inspection No. / No de l'inspection : 2015_348143_0026 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-002281-15 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Nov 03, 2015;(A1)

Licensee / Titulaire de permis : CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9

LTC Home / Foyer de SLD : CARESSANT CARE MARMORA
58 BURSTHALL STREET, P.O. BOX 429, MARMORA, ON, K0K-2M0

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Cindy Brandt

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To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. The plan shall also include all recruiting and retention strategies.

This plan is to be submitted in writing by August 7th, 2015 to Paul Miller at 347 Preston Street, 4th floor, Ottawa, Ontario, K1S 3J4 or by fax at 613-569-9670.

Grounds / Motifs :

1. The licensee has failed to ensure that a Registered Nurse (RN) is on duty and present at all times.
Caressant Care Marmora is an 84 bed Long-Term Care Home.
A review of Caressant Care Marmora Registered Staffing Schedule for the period June 8 2015 to July 6th, 2015 indicated the following:
On June 8th, 9th, 10th and 11th the home did not have a RN present in the home for the evening shift (1400 hours to 2200 hours).
On June 16th the home did not have a RN from 2200-0600 hours.
On June 20th the home did not have a RN from 1400 to 0600 hours (2 shifts).
On June 21 and 22nd the home did not have a RN from 1400 hours to 2200 hours
June 23rd and 24th the home did not have a RN from 2200 hours to 0600 hours.
On June 28th the home did not have a RN from 1400 hours to 2200 hours.
On July 1st the home did not have a RN from 2200 hours to 0600 hours.
On July 4th the home did not have a RN from 1400 hours to 2200 hours.
On July 6th the home did not have a RN from 1400 hours to 2200 hours.
Ontario Regulation 79/10 section 45.(2) indicates that "emergency" means an unforeseen situation of a serious nature that prevents a Registered Nurse from getting to the long-term care home. The thirteen shifts were reviewed and discussed with the Administrator who confirmed that an emergency did not exist where the exception as per Ontario Regulation 45.(2).ii would apply. The Administrator reported that a Registered Practical Nurse was scheduled when a RN was not on duty and present in the home. The Director of Nursing reported to the Inspector that the home currently has a full time RN on maternity leave. The Director of Nursing reporting that the home had advertised the vacant position but was not successful in recruiting a RN for a temporary position.
On July 6th, 2015 Resident #11 on or about 1940 hours successfully exited the building despite wearing a functioning wanderguard bracelet. The resident sustained a fall during the elopement and sustained minor injuries. During this period of time no RN was on duty and present in the home. (143)

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

Jan 31, 2016(A1)

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

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

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

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

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
Toronto ON M5S 2B1
Télécopieur : 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
Toronto ON M5S 2B1
Télécopieur : 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 3 day of November 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : AMBER MOASE - (A1)

Service Area Office /
Bureau régional de services : Ottawa