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
Nov 30, 2015	2015_286547_0021	O-002653-15	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

MONTFORT
705 Montreal Road OTTAWA ON K1K 0M9

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

LISA KLUKE (547), ANGELE ALBERT-RITCHIE (545), JOANNE HENRIE (550), MELANIE SARRAZIN (592)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 14-15-16-19-20-21-22-23-26, 2015

The following critical incidents and a complaint inspections were conducted concurrently during this inspection: Log #O-002200-15, #O-002142-25, #O-002729-15 and #O-002555-15.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), the Documentation Manager/RAI Coordinator, the Resident /Family Services coordinator, the Activity Director, the Environmental manager, an Environmental Services worker, the Registered Dietitian, Food Services Supervisor, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeepers, Laundry aides, dietary aides,the President of Resident's Council, the previous President of Family Council until September 2015, Residents and Family Members.
In addition the inspection team, reviewed resident health care records, food production documents including planned menus, Resident Council minutes, Family Council minutes, documents related to the home's investigations into alleged incidents of abuse/neglect and policies related to restraint use, falls prevention, medication management and prevention of abuse. The inspection team observed aspects of resident care and interactions with staff, along with medication administration and several meal services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Admission and Discharge
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
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **15 WN(s)**
- **6 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 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 :

The licensee has failed to ensure that Registered Nursing Staff in the home follow the home's policy and procedures from Revera regarding: Medication Administration, Management of Narcotic and Controlled Drugs and Self-Administration of Medication.

Regarding the Medication Administration and Management of Narcotic and Controlled Drugs policies:

On October 21, 2015 Inspector #545 observed the following medications (narcotic and controlled drugs) missing from their packaged blister packs in the locked drawer of the locked medication cart during a morning medication pass observation:
1) Narcotic medication for Resident #042 had 26 tablets left in blister pack, narcotic sheet indicated 28
2) Narcotic medication for Resident #043 had 19 tablets left in blister pack, narcotic sheet indicated 21
3) Narcotic medication for Resident #044 had 26 tablets left in blister pack, narcotic sheet indicated 28
4) Controlled drug for Resident #045 had 26 tablets left in blister pack, narcotic sheet indicated 28
5) Narcotic medication for Resident #046 had 26 tablets left in blister pack, narcotic sheet indicated 28
6) Narcotic medication for Resident #047 had 19 tablets left in blister pack, narcotic sheet indicated 21

Inspector #545 further observed these missing narcotic and controlled drugs pre-poured in medication cups in several Residents' unlocked bins in the single-locked medication cart.

During an interview with RPN #123, she indicated to Inspector #545 that when she had removed the 0800 dose earlier in the day, she had, by error, removed a second tablet from the packaged blister pack. She further indicated that she had administered one tablet prior to 08:00 then pre-poured a second tablet into a medication cup for the noon dose then placed each cup in the Resident's bins. RPN #123 indicated that it should not be a problem since she was the only Registered Nursing staff with the key to the Medication Cart.

The DOC indicated to Inspector #545 on October 21, 2015 that medications must remain

in the original labelled container(s) or package(s) provided by the pharmacy service provider until administered to a resident and that all medications will not be prepared in advance (pre-poured) under any circumstances. The DOC further indicated that all narcotics and controlled drugs should be secured by double locking, at all times, and that all Registered Nursing staff had been informed to not leave narcotics outside of the double-locked narcotic storage area.

Upon review of the home's policy and procedure from Revera LTC-F-20 regarding the administration of Medications last revised August 2012 stated on page 1 of 3:
- #3.Medications must remain in the original labelled container(s) or package(s) provided by the pharmacy service provider or the Government supply until administered to a Resident.
- #6. Medications will not be prepared in advance (pre-poured) under any circumstances.

Upon review of the home's policy and procedure from Revera LTC-F-80 regarding the Management of Narcotic and Controlled Drugs last revised August 2012 stated on page 1 of 3:
- #4. All narcotic and controlled drug(s) will be secured by double locking.

On October 21, 2015 Inspector #545 observed RPN #123 administer several medications to Resident #041 between 08:00 and 08:15. Out of these medications that was administered, a signature was not found when the Medication Administration Record (MAR) was reviewed by Inspector #545 at 08:45 this same day. Inspector #545 further noted that the medications (narcotic and controlled drugs) missing from their packaged blister packs as noted above were also not signed for after the morning medication administration.

Upon review of the home's policy and procedure from Revera LTC-F-20 regarding the Administration of Medications last revised August 2012 stated on page 2 of 3:
- #15. All medication administered, refused or omitted will be documented immediately after administration on the MAR/TAR using the proper codes by the administering nurse.

Regarding the Self Administration of Medication policy:

On October 15, 2015 and October 21, 2015 one large jar of prescribed cream was observed on the counter in the bathroom of Resident #035 by Inspector's #545 and #547. Resident #035 indicated to Inspector #545 that the resident applied this prescribed

cream to self twice daily.

During an interview with PSW #124, she indicated to Inspector #545 that Resident #035 self-applied the prescribed cream twice daily and that it was kept in the resident's bathroom for easy access. RN #100 indicated that Resident #035 was admitted with the prescribed cream and that the resident was independent with the application. She further indicated that the prescribed cream was kept at the resident's bedside for easy access to apply twice daily.

The DOC indicated that all medications including prescribed creams that Residents can self-administer were to be stored in a locked bedside drawer in their rooms.

Upon review of the home's policy and procedure from Revera LTC-F-100 regarding Self Administration of Medication last revised August 2012 stated on page 2 of 3:
- #9. All medications will be stored in a locked bedside drawer/cabinet to which the Resident and Nurse will have the key.

It is noted that this area of non-compliance related to not following the home's policy and procedure regarding "Administration of Medications" was previously left as VPC for the 2014 RQI for this home.[s.8(1)b] (545)

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with 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. (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 has failed to ensure that the plan of care set out clear directions regarding dental care to staff and others who provide direct care to Resident #016.

Resident #016's most recent assessment indicated the Resident required total assistance of one person for personal hygiene, including dental care.

On two specified dates in October 2015 Resident #016 indicated to Inspector #545 that his/her dentures were loose and believed that he/she had a paste to help them remain in place.

In a review of the most recent plan of care, it was indicated that the Resident wears two dentures and was independent for oral care.

Interviews with PSW's #109 and #108 on October 19, 2015 with Inspector #545, they indicated that the Resident required assistance with dental care, and that often staff had to help remove the dentures as the resident could not remember how and that the cleaning of the dentures was completed by PSW's. Neither PSW was aware that the

Resident complained of loose dentures. PSW #108 further indicated that she was not sure where to locate the Resident's plan of care.

RPN #107 reviewed the most recent plan of care accessible to the PSW, a printed copy which indicated that the plan of care did not set out clear directions to staff and others who provide dental care to Resident #016. She further indicated that she was aware that the Resident required extensive assistance with his/her care. [s. 6. (1) (c)]

2. The licensee failed to ensure the care set out in the plan of care regarding bathing is provided to Resident #019 with two PSW's as specified in the plan.

Resident #019 has several medical conditions including mental illness and it was documented on an assessment that the Resident was verbally and physically abusive one to three days in the past seven days and socially inappropriate/disruptive behaviour on a daily basis with moods that are not easily altered.

Upon review of the most recent plan of care for Resident #019, it was indicated that Resident #019 required assistance of two staff for bathing, dressing as the Resident's responsive behaviours included a tendency to confabulate.

On a specified date in October, Resident #019 reported to Inspector #545 that PSW #120 hit the resident while bathing approximately one month ago and that other PSWs now provide assistance with bathing.

Inspector #545 reviewed the unit’s staff communication book and noted the DOC wrote a staff reminder note on a specified date in September 2015: "due to responsive behaviours Resident #019’s bath would be provided by two staff members as per plan of care".

During an interview with PSW #120 she indicated to Inspector #545 that she remembered the incident when she was providing Resident #019 a bath by herself. PSW #120 indicated that Resident #019 became agitated and hit her in the face and eye when the PSW declined to provide the resident with a fourth shampoo. This PSW indicated that when she informed Resident #019 that she would be reporting this action to management, the Resident responded with a statement that was in line with the resident's known pattern of behaviour to tell everyone that PSW #120 hit the resident first and was the reason the resident hit the PSW.

RN#132 indicated to Inspector #545 that PSW #120 and Resident #019 were arguing when she entered the tub room and added that she had, in the past, alerted the day staff that a different PSW should be assigned to provide this Resident a bath as they no longer got along. RN #132 confirmed that only one staff member was providing Resident #019's this bath.

The DOC indicated to Inspector #545 that she was aware that PSW staff did not provide two person care to Resident #019 at all times as per the plan of care. She indicated that staff were reminded after the incident to ensure that the plan of care was followed, due to the Resident's responsive behaviours. [s. 6. (7)]

3. The licensee has failed to ensure that Resident #050, Resident #030 and Resident #035 were reassessed and their plans of care reviewed and revised when the residents care needs changed.

Resident #050 sustained reddened excoriated areas as reported to Inspector #550 by RN #122 on October 23, 2015. The resident's progress notes indicated that the resident was found on a specified date in September at the beginning of the day shift by PSW #118, with dried feces on the resident's skin along abdomen and then observed there was no prosthetic medical device in place.

Inspector #550 reviewed Resident #050's written plan of care at the time of the incident and noted the care plan had not been updated to reflect the resident's new alteration in skin integrity.

The DOC indicated to Inspector #550 that Resident #050's plan of care should have been revised and updated when the resident sustained a new issue of altered skin integrity. [s. 6. (10) (b)]

4. Resident #030 was admitted with a cognitive disorder and had been identified as high risk of falls. Resident #030 was ordered a seat belt restraint for safety measures due to having several falls, despite all other measures in place to protect the resident.

On October 23, 2015 Inspector #547 reviewed Resident #030's health records and noted that the Resident's care plan did not reflect the front closure seat belt restraint ordered for the resident when seated in a wheelchair. Resident #030's care plan was last updated on a specified date in September 2015.

On October 23, 2015 the DOC indicated to Inspector #547 that she was not aware of this new order for restraint for this Resident, and that Resident #030's care plan should have been updated on the day the front closure seat belt restraint was ordered. [s. 6. (10) (b)]

5. Resident #035 had a fall during a self-transfer from a chair in the resident's room to go to the bathroom on a specified date in August 2015 as identified during an interview with RN #100. Resident #035 returned from hospital with a cast from fracture.

Resident #035's care plan was created after admission to the home. This care plan identified this resident with history of falls but had no identified interventions related to this risk.

On October 20, 2015 RN #100 reviewed Resident #035's care plan with Inspector #547 and noted that the paper copy of the resident care plan from admission was not updated until a specified date in October 2015. Resident #035 had a cast for this fracture from a specified date in August to a specified date in September 2015 and no clear documented interventions were noted anywhere in the resident's plan of care. RN #100 indicated no interventions related to the resident's cast care, comfort measures, positioning and transfers with fracture, or assessment of pain were identified.

On October 21, 2015 Inspector #547 reviewed Resident #035's progress notes, that further identified the resident was provided an air cast in September after the cast was removed, and directions provided were to keep the air cast in place at all times, but could be removed for bathing. On a specified date in September 2015, 8 days after the air cast began to be used, the resident was noted to have an open area to the right leg, from rubbing against the air cast. The physio asked the nurse to assess the resident's leg to see if there was a wound 2 days later, and the nurse noted that there was an open area as this was not previously identified in the plan of care. Directions in the progress notes then indicated that the resident should have the air cast removed every night when in bed, but that it would need to be applied every time the resident needs to get up to go to the bathroom and would require assistance for this.
Resident #035's care plan was not updated until a specified date in October 2015, 25 days after the nurse assessed the resident with an open area from this air cast.

Inspector #547 noted that Resident #035's updated care plan of October 2015 identified complications from fracture with a skin wound requiring dressing changes since a specified date in September 2015. These changes in Resident #035's plan of care were not identified in the care plan until October 2015, 28 days later.

RN #100 indicated to Inspector #547 that Resident #035's care plan should have been updated manually on the paper copy in the binder for PSW staff and electronically updated in Mede-care to reflect all the Resident's changes in care needs. [s. 6. (10) (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 residents are reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The following home areas were noted to be unclean during the course of this inspection:

On October 14, 2015 during the initial tour of the home, Inspector #545 noted that the public bathroom on the second floor near the Pommeraie unit was soiled with dried yellow/brown matter around the base of the toilet, the flooring was stained in front of the toilet and a lingering odour of urine was present. The public bathroom on the first floor

near Allee des Tulipes unit was also noted to have odours whereby the base of toilets were soiled with yellow/brown matter.

On October 15 and 16, 2015 Inspector #547 observed the following in resident rooms:

A specified resident room- the resident's bathroom had yellow/orange matter around the base of the toilet and floor.
A specified resident room- the resident's bed rails, bathroom counter and light switch plates have dried food matter, dust and debris.
A specified resident room- the resident's bed rails were sticky with dried food matter, the wall next to the resident's bed had dried brown matter, the resident's shared bathroom had dried yellow/brown matter on the call bell switch plate next to the toilet.
A specified resident room- the resident's bed rails had heavy amount of dried food matter and debris, the resident's lazy boy chair had white matter streaks and the resident's glass side table had a large build up of dust and dried food matter.

On October 19, 2015 Inspector #547 interviewed the Environmental Manager who indicated the housekeepers for resident rooms are expected to tidy and clean rooms daily including washing toilets, counter and contact surfaces. Resident bed rails and contact surfaces such as light switches, walls, and furniture are washed as required for any food debris, or dried matter. Floors are swept and mopped, and if carpeting, debris is picked up as required.

The home has deep clean schedule set up on every unit for housekeeping of spa rooms every weekend. Upon observation of the spa rooms on the Pinneraie and Pommeraie units on October 19, 2015 the Environmental Manager indicated that it was evident that the deep cleaning of these spa rooms was not done on the weekend as per the planned schedule. Heavy build up of dried orange soap streaks on the walls near the liquid soap dispenser, heavy build up of dried matter behind the sinks, and lingering musty odour in these showers, where floor grip strips were noted to have a build up of grey, orange matter. In the Spa room on the Pinneraie unit, medicated patches were found stuck to the door inside the tub area of the spa room, as well as on the side of the wall of the shower in the shower area of the spa room. The Environmental Manager indicated that this was unacceptable from both a nursing department and housekeeping department.

On October 20, 2015 Inspector #547 interviewed the DOC regarding the housekeeping issues of high touch surfaces identified above for resident care areas. The DOC indicated that all staff are responsible to clean areas such as these and that antibacterial

wipes are provided and available for all staff to use and should be easily wiped away by anyone who sees it, just as any spill on the floor. During our discussion at the nursing station in the Pommeraie unit, an area under the desk facing the main hallway and dining room for this unit, we noted a large area of dried brown matter on the back wall of the desk. The DOC indicated that this was not acceptable. DOC was also made aware of the medicated patches found in the Pinneraie spa room as identified above that nursing staff did not properly dispose.

The following furnishings were noted to be unclean during the course of this inspection:

Inspector #547 noted for the duration of this inspection, that two pink cloth sitting chairs located in an alcove on the Pommeraie unit used by Residents and visitors were noted to have dried white matter to the seat, arms rests and wooden bases of these chairs. On October 19, 2015 the Environmental Manager was made aware.

The following resident equipment was noted to be unclean during the course of this inspection:

-On October 16, 2015 Inspector #545 noted that Resident #016's manual wheelchair was unclean as the seat cover was heavily soiled with white debris and dried matter.

-On October 16, 2015 Inspector #592 noted that Resident #013's walker had excessive dust on frame and seat cushion.

On October 19, 2015 Inspector #547 interviewed PSW #106 who indicated that the residents ambulation equipment such as walkers, canes and wheelchairs are cleaned on night shift on a specified rotation schedule by PSW staff.

On October 21, 2015 Inspector #547 noted Resident #021 in the main entrance of the home and the resident's restraint had significant build up of stains and white matter. the resident's chair was also noted to have a significant amount of dust, debris, and food matter to the frame. Resident #019 was also noted in this main entrance to the home, and noted the resident's wheelchair also had a heavy build up of dust, debris and dried food matter. The DOC was made aware of the situation of these wheelchairs.

On October 22, 2015 Inspector #547 observed Residents #019 and #021's wheelchairs again that continued to have dust, debris, dried food matter and stains. Resident #019 was scheduled to have wheelchair cleaned on October 21, 2015 as per the set cleaning

schedule. Resident #021 was scheduled to have wheelchair cleaned daily. Resident #013's walker continued to have dust and debris as originally identified.

Inspector #547 then interviewed the DOC regarding the home's equipment cleaning schedule and indicated that every resident unit has a set schedule for cleaning of resident equipment on night shift by PSW staff. The DOC noted that these resident chairs continued to have a heavy build up of dust, debris and dried food matter or stains as identified the day earlier, and the week earlier and had not been cleaned. Upon closer review of the equipment cleaning lists, it was noted that Resident #013 was no longer even on any rotation list for cleaning of this walker. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On October 16th, 2015, Inspector #592 observed in a specified resident room a raised toilet seat on top of the toilet without any method of being secured. When Inspector #592 touched the raised toilet seat, the position of the seat was easily altered, posing a risk to the safety of the resident as the toilet seat was not fitting appropriately on the toilet.

Upon showing the raised toilet seat to RN #104, she told Inspector #592 that the raised toilet seat was safe and secure for the resident. While conducting the interview with RN #104, Housekeeper #103 told Inspector #592 that she was responsible to report any areas or equipment in disrepair to the Registered Nursing staff. Housekeeper #103 reported to Inspector #592 that she had reported several times to Registered nursing staff members on the unit that the raised toilet seat was not fitting the toilet and was unsafe for the Resident in this room. No documentation was located of these reports.

On October 16, 2015, Inspector #592 interviewed the Environmental Manager who indicated that there was no process in place for the monitoring of the raised toilet seat equipment other than regular check by Housekeeping staff who will report any disrepair to the Registered Nursing staff or directly to the Maintenance department when doing their daily cleaning. The Environmental Manager indicated to Inspector #592 that he was not made aware of the unsafe condition of this raised toilet seat in this resident's room and was going to do a follow-up.

On October 19, 2015 the Environmental Manager reported to Inspector #592 that the raised toilet seat in this resident's room was changed on the same day that it was reported by Inspector #592 as it was not maintained in a safe condition and could have

caused resident injury. [s. 15. (2) (c)]

3. On October 16 and 23, 2015, Inspector #547 and #545 observed two half rails on Resident #028’s bed. The bed rail closest to the bathroom was noted to be loose and when pulled away from the bed frame, it provided a four inch gap from the mattress. The Resident's right bed rail is also loose, and it was noted that the bottom end of the mattress can be moved to the side easily providing an even larger gap of seven inches between the bed rail and the mattress.

According to Resident #028's health records, the Resident requires half rails as well as assistance of two persons for transfers and bed mobility. Upon review of the most recent care plan, staff were to encourage Resident #028 to hold on to the bed rails during repositioning every two hours when in bed.

During an interview with PSW #133, she indicated that Resident #028 used the bed rails for repositioning when in bed and was not aware that the bed rails were loose.

RPN #134 indicated that when any equipment was in disrepair, staff were expected to contact by phone the Environmental Manager for assessment and repair. RPN #134 reported to Inspector #545 that both bed rails were in need of repair and she would contact the Environmental Manager to request immediate repair to the resident's bed rails.

On October 23, 2015 the Environmental Manager indicated to Inspector #592 that the bed assessment had been done by an external company on a specified date last Summer and that Resident #028’s bed had passed. The Environmental Manager assessed Resident #028's bed rails and indicated that both bed rails required immediate repair to increase Resident’s safety and that anyone can report items in disrepair to the maintenance department. [s. 15. (2) (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 to ensure that the home, furnishings and equipment are kept clean, maintained in a safe condition, and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of physical abuse of Resident #019 by anyone that the licensee knows of, or that is reported to the licensee, was immediately investigated.

Physical abuse is defined by the LTCHA, 2007 as "the use of physical force by anyone other than a resident that causes physical injury or pain,".

Inspector #545 reviewed the home's abuse policy titled "Resident Non-Abuse - Ontario, LP-C-20-ON with a revision date of September 2014 which was their most recent policy as indicated by the DOC. The policy indicated: "An immediate and thorough investigation

of the reported alleged, suspected or witnessed abuse or neglect will be initiated by the Home's ED/designate. The resources Tool Kit for Conducting an Alleged Abuse Investigation and/or Tips for Handling a Third Party Investigation may be referenced when conducting the investigation".

Resident #019 reported to Inspector #545 that a PSW hit the resident while receiving a bath, approximately one month ago, and that other PSWs now provide assistance with bathing.

In a review of the Resident's health record, a progress note on a specified date in September 2015 indicated that the Resident had reported being hit by a PSW during bath time. Following investigation by the DOC, she concluded that there had been no physical abuse by PSW #120 towards Resident #019.

During an interview with PSW #120 she indicated that she remembered this incident when she was providing Resident #019 a bath. The PSW indicated that the Resident became agitated and hit her in the face and eye when she declined to provide the resident with a fourth shampoo. The PSW indicated that when she informed the Resident that she would be reporting this action to management, he/she responded that he/she would tell everyone that the PSW hit the resident first and that was the reason the resident hit back. PSW #120 further indicated that she then called for assistance and reported the incident immediately to the Registered Nursing staff.

RN #132 indicated to Inspector #545 that PSW #120 and Resident #019 were arguing when she entered the tub room, and that she had in the past alerted the day staff that a different PSW should be assigned to provide this Resident a bath as they no longer got along. RN #132 further indicated that she reported the incident to the day nurse, added that the DOC was aware as had added a note in the Communication Book shortly after the incident.

During an interview with the DOC on October 22, 2015 she indicated that she became aware of the incident on this specified date in September but did not conduct an investigation immediately when she became aware of the alleged abuse until the following day, when PSW #120 was available for an interview. [s. 23. (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 to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that is reported to the licensee is immediately investigated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when Nursing Staff had reasonable grounds to suspect that improper or incompetent treatment of care of Resident #050 that resulted in harm, immediately report their suspicion of neglect and the information upon which it was based to the Director.

For the purposes of the definition of "Neglect" is defined as per O.Reg.79/10,s.5.: "Neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On a specified date in September 2015 at the beginning of the day shift, PSW #118 noticed a strong odour of feces coming from Resident #050's room. When PSW #118 proceeded to do morning care, she noted the prosthetic medical device was not in place and the resident had dry crusted feces to the chest and abdomen. PSW #118 further noticed the Resident's incontinence product was saturated with urine and feces. When PSW #118 washed the resident, she observed the Resident's skin was red and excoriated; the resident was tearful during the procedure and complained of discomfort. PSW #118 notified RN #137 of the incident of suspected neglect from the night PSW.

Inspector #545 reviewed a copy of the home's current policy and procedure "Resident Non-Abuse-Ontario" Index: LP-C-20-ON last revised September 2014. Mandatory Reporting states on page 4 of 14:

- A staff member or person, who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a Resident must immediately report that suspicion and the information on which it is based to the Executive Director (ED) of the home or, if unavailable, to the most senior Supervisor on shift at that time.

During an interview, PSW #118 indicated to Inspector #550 that she immediately informed RN #137 of the suspected incident of neglect of Resident #050 however RN #137 was not the most senior Supervisor on shift at that time. Both Nursing staff members indicated that they did not report their suspicion to the Director.

This policy further states on this same page:
Mandatory reporting under the LTCHA (Ontario): Section 24(1) of the LTCHA requires a person to make an immediate report to the Director where there is a reasonable suspicion that certain incidents occurred or may occur. LTCHA provides that any person who has reasonable grounds to suspect that improper or incompetent treatment of care of a Resident that resulted in harm or risk of harm to the Resident, must be immediately report the suspicion and information upon which it is based to the Director of the Ministry of Health and Long-Term Care.

PSW #118 or RN #137 did not immediately report to the Director of the Ministry of Health and Long-Term Care, their suspicion of Resident #050's treatment of neglect by another staff member that resulted in harm to this Resident. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that neglect has occurred with a resident, that they immediately report their suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #017 and Resident #050 exhibiting altered skin integrity or skin breakdown, receive 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.

Resident #017 is diagnosed with several medical conditions including a blood disorder and visual impairment and according to the physician orders, the Resident is

administered salicylate medication on a daily basis.

On October 16 and 20, 2015 Inspector #545 observed two dark purple bruises on Resident #017's body limb, approximately 3.5cm in diameter. The Resident indicated that in the recent months to have noticed that he/she was bruising very easily. Resident #017 indicated that these bruises might have occurred when he/she bumped his/her limb on the foot board of the bed at night while adjusting the comforter.

Inspector #545 reviewed Resident #017's health records and noted progress notes dated from two specified dates in September 2015 that indicated the Resident complained of bruising very easily and frequently over the past month. Documentation of a skin assessment was not found.

Inspector #545 reviewed the Daily Flow Sheets completed by PSWs and noted that bruising was documented on a specified date in August 2015 and a specified date in September 2015.

PSW #120 and PSW #112 indicated to Inspector #545 on October 20, 2015 that during bath time, a skin observation was conducted and that it was their responsibility to report any altered skin integrity, including bruises to the Registered Nursing staff. They indicated that the Resident was bathed twice weekly on Monday and Thursdays, and that they had not noticed the bruises on Resident #017. PSW #112 further indicated after looking at the Resident's limb, that the bruises were obvious but she had missed them.

RPN #111 indicated to Inspector #545 that Registered Nursing staff were responsible to assess all bruises and document in the progress notes location, measurement and cause of bruise, if known, then notify the physician and family. She indicated that the bruises observed on the two specified dates in September by staff did not include a skin assessment or notification to family. She further indicated that she was administering medications to the Resident on a daily basis, and had not noticed the bruises on Resident #017.

During an interview with the DOC, she indicated that according to the Home's Skin and Wound Program, altered skin integrity refers to the potential or actual disruption of epidermal or dermal tissue, which includes all skin breakdown, including but not limited to bruises, skin tears, rashes, wounds/ulcers, burns and lesions. She indicated that when Resident #017 exhibited bruising on the first specified dates in September and October that a skin assessment by a member of the Registered Nursing staff should have been

completed. [s. 50. (2) (b) (i)]

2. The home submitted a critical incident report on a specified date in September 2015 to the Ministry of Health and Long-term Care Director regarding Resident #050 who sustained red excoriated areas to the abdomen from a lack of care. On a specified date in September 2015 at the beginning of the day shift, Resident #050 was found by PSW #118 in bed with dried feces from chest to abdomen as no prosthetic medical device was in place at that time.

Inspector #550 reviewed Resident #050's health records and was unable to find any 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 other than a progress notes indicating redness was observed under and around the Resident's abdomen.

The DOC indicated the home's expectation is that Registered Nursing staff would have conducted a skin assessment using the "Evaluation complète de l'épiderme" form for Resident #050 as the integrity of skin was compromised. The DOC further indicated to Inspector #550 that if the skin assessment is not found in the Resident's health records it was not done and that staff may have forgotten to complete it. [s. 50. (2) (b) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when any resident exhibiting altered skin integrity or skin breakdown in the home should have a skin assessment completed using the home's "Evaluation complète de l'épiderme" assessment, to be implemented voluntarily.

WN #7: 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).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Resident Council was sought out for advice in developing and carrying out of the satisfaction survey, and in acting on its results.

On October 19, 2015, Inspector #592 interviewed a member of the Resident Council who indicated that he was given a copy of the survey however members of the Resident Council were not given the opportunity to offer advice on the survey or how it would be carried out in their home.

On October 19, 2015, Inspector #592 interviewed the assistant of the Resident's Council and the Director of Care who both indicated that the satisfaction survey was provided by Revera, and both were not aware that the home had to ask for the Resident Council's advice in developing of the satisfaction survey or how it was to be carried out in their home.

This area of non-compliance was previously left in the 2014 RQI as a written notification. [s. 85. (3)]

2. The licensee has failed to document and make available to the Residents' Council, the results of the satisfaction survey in order to seek the advice of the Council about the survey.

On October 19, 2015, Inspector #592 interviewed two members of the Resident Council who both indicated that following the completion of the satisfaction survey this summer, the results were not documented or made available for them to review.

On October 19, 2015, Inspector #592 interviewed the assistant of the Resident's Council who indicated that she did not know that she had to seek the advice from the council in developing the satisfaction survey or that she should share the results of this survey to the Resident Council. [s. 85. (4) (a)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a resident-staff communication response system that can be easily seen, accessed, and used by residents, staff and visitors at all times.

Resident #019 has several medical conditions requiring extensive assistance for most activities of daily living.

On October 16, 20 and 21, 2015, a large grey bubble-like call bell was observed in the Resident's room, wrapped around the bed rail which was in the down position and a comforter was covering the cord and call bell. The Resident's bed was placed against the wall. Resident #019 indicated that he/she would be unable to reach the call bell as the resident could not access it while sitting in a wheelchair.

Upon review of the Resident's most recent plan of care, it was documented that Resident #019 was at high risk for falls and required assistance for transfers and that staff were directed to ensure that the call bell was accessible at all times and to encourage Resident to call for assistance.

During an interview with PSW #128, she indicated to Inspector #545 that all residents must have a call bell that they can easily access at all times. PSW #128 indicated to Inspector #545 in Resident #019's room that this Resident would not be able to access the call bell then left the room.

The Documentation Manager indicated that Resident #019 would not be able to access the call bell due to the resident's restricted range of motion and that an assessment of a call bell was required to provide the Resident with a resident-staff communication response system that was easily seen, accessed and used by the Resident, staff and visitors at all times. [s. 17. (1) (a)]

2. On October 15, 20 and 21, 2015 the call bell cord in Resident#038's room was observed rolled up behind the resident's bedside table. The Resident indicated that he/she did not have a call bell.

Upon review of the Resident's most recent plan of care, it was documented that Resident #038 ambulated with a cane and suffered frequent episodes of dizziness, therefore staff were directed to ensure that the Resident's call bell was easily accessible and to remind Resident #038 to use the call bell as needed.

During an interview with PSW #124, she indicated to Inspector #545 that all residents must have a call bell that they can easily access at all times. PSW #124 indicated to Inspector #545 in Resident #038's room that the Resident would not be able to see and/or access the bedside call bell cord the way it is currently located.

The Documentation Manager indicated that the home expected all staff to ensure that a resident-staff communication response system cord (call bell) be easily seen, accessed

so that residents, staff and visitors can use at all times when needed. She indicated that Resident #038 and #019 did not have call bell cords that were easily seen or accessible. [s. 17. (1) (a)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy titled "Least Restraints" was complied with for Resident #030.

Resident #030 was admitted to the home with a specified cognitive disorder and has been identified as high risk of falls. Resident #030 was ordered a front closure seat belt restraint on a specified date in October 2015 for safety measures as the resident has had several falls, despite all other measures in place to protect the resident.

Inspector #547 reviewed the home's Revera policy titled Resident Safety #LTC-K-10 last revised March 2013 that indicated on page 2 of 3 that :

#5-the resident care plan must be current to reflect the use of restraint, interventions and potential risks.
#6-the home will have a monitoring, repositioning/release and documentation process in place for all residents who are restrained.

On October 23, 2015 Inspector #547 reviewed the Resident's health records and noted that the Resident's care plan did not reflect the residents need to wear a front closure seat belt restraint while in a wheelchair. The resident's care plan was last updated in September 2015.

The home's restraint monitoring record " Formulaire d'observation des contentions" for Resident #030 was reviewed by Inspector #547 and RPN #134. RPN #134 indicated that the home's expectation regarding this documentation form for restraints, is the Registered Nursing staff verifies that the resident is wearing the restraint, and that it is applied safely. RPN #134 further indicated that Registered Nursing staff do not reposition

the residents every two hours, as the PSW staff would do this. PSW staff applies the device when they get the resident into a wheelchair and remove it when they transfer them out of the wheelchair. Registered Nursing staff are responsible to complete these documents. PSW staff do not have any documentation regarding restraints in the home. RPN #134 signed in the box for PSW initials on a specified date in October 2015 as she did not realize PSWs are intended to sign this form.

Resident #030's restraint monitoring record did not have any identified removal/ repositioning or assessment required every two hours for this resident's seat belt restraint since it was initiated on a specified date in October 2015. On a specified date in October 2015, Resident #030's restraint was applied and recorded by RPN #134 hourly from 07:30-13:30 when it was removed. RPN #134 indicated to Inspector #547 that she knew to initial that it was removed at this time as the resident goes to bed every afternoon at 13:30. RPN #134 indicated she did not apply the resident's restraint every hour during this period as PSW's do this but she is documenting that this is done.

The documentation record for October 2015 did not identify the PSWs who applied or removed the device on three out of six shifts. The Documentation record also did not identify the Registered Nursing staff assessment regarding resident's response and re-evaluation of the Resident's new restraint device applied while in a wheelchair. [s. 29.]

WN #10: 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 has failed to ensure that the organized maintenance program under s.15. (1)c. of the Act, that there must be a description of the program that includes its goals and objectives and relevant policy and procedures related to the maintenance of the current heating system in the home.

On October 15, 2015 Inspector #547 interviewed Resident #032's family member who is also a volunteer in the home. Resident #032 will often complain to her family member that it is too hot in the resident's room. Resident's family member indicated that he/she have also noted when the temperatures change outside to colder weather, that the home is often very warm.

The Inspection team also noted on October 14,15,16 and 19, 2015 that the Resident hallway on the Pommeraie unit to be very warm. During this time, several resident room windows were noted to be open, and Resident #032 was observed to often be sitting in

his/her room next to the open window in the afternoons.

On October 20, 2015 PSW #101 and #102 asked Inspector #547 to verify temperatures in resident rooms specifically Resident #052's room that was very hot at this time. Resident #052 prefers to keep the bedroom door closed and does not want to open the window. Upon entree to this resident room, it was noted that the air was very warm. Resident #052 had a portable thermostat located on the resident's bedside table that indicated 32 degrees Celsius. This resident had flushed cheeks and verbalized that the bedroom was very hot, as the PSW staff forgot to turn on the stand up fan near the door for air to circulate around the room. PSW #101 indicated that it is only a few rooms on this wing like this, but very uncomfortable for residents to live in.

Inspector #547 called Environmental Services Staff #119 to verify Resident #052's temperature as there was no wall thermostat mounted in this room. Staff #119 indicated that resident rooms are set up so one thermostat regulates four rooms at a time. When reviewing the thermostat responsible to the heating in this specified resident bedroom, it was located 2 resident rooms down the hallway. This wall mounted thermostat was set to Max 32 degrees Celsius. Environmental Services Staff #119 indicated that this would be why these rooms were very warm. PSW #101 and #102 in this hallway indicated that the home was too hot, and that it was like this for a long time.

Environmental Services Staff #119 indicated that the home's expectation for maintenance of the home's heating system is that Environmental Services department are to verify every wall mounted thermostat in the morning when they arrive, to ensure they are set to 22 degrees and they are suppose to re-adjust at the end of shift, if the night is suppose to be cold and turn on the heating system. Environmental Services Staff #119 indicated this is a difficult time of year to manage the heat, so they manually verify each thermostat every day. The thermostats are kept behind a lock box, that environmental services have access to with a key. Environmental Services Staff #119 indicated that he had not verified the thermostat in this specified room affecting these residents this morning as the specified resident door was closed and he did not want to disturb the resident. Inspector #547 and Environmental Services Staff #119 further observed another specified Resident room on Allee des Tulipes unit that had the wall mounted thermostat set to 28 degrees Celsius. The small dining room on this unit was also noted to be set to 26 degrees Celsius.

On October 23, 2015 Inspector #547 interviewed the Environmental manager regarding the heating/thermostat process in the home for resident care areas. The Environmental

Manager indicated that the thermostats are to be verified each morning by the Environmental Services staff and adjusted accordingly with the weather outdoors. Thermostats are turned down during the day when the weather is warmer in the day time. Thermostats are then to be verified again at the end of day by the Environmental Services staff to verify they are properly set to heat for the night. The Environmental manager indicated that the thermostats require boost action when it starts to get cold outside by placing the prong on the thermostat to max heat. This heating system is an older system, and this action makes the heating system ignite. The prong on the thermostat has to stay on max for a five minute period of time and then the Environmental Services staff have to return to these thermostats to manually reduce the prong to 22 degrees in order to set the minimum temperature as per regulations.

The Environmental Manager identified that the home does not have any policy or procedure related to their specific needs for the heating system in the home at this time. The Environmental Manager indicated that the heating system was started in the home when it started to get cold outside and did not have any date, but thought that it may have been at the end of the first week of October 2015. He further indicated that he has trouble with the keys in the home for these thermostats as several staff have them so they all go and adjust them manually. He has little control except the morning and night when Environmental Services staff are in the home. He indicated that Environmental Services staff are aware that this is required to be done, but no process, documentation or monitoring of this system is currently in place to know when each thermostat is ignited, then manually set to 22 degrees or when they are turned off.

The Administrator indicated to Inspector #547 that she was not aware of this informal process for heating in the home and that there was no set policy and procedure that speaks to their current heating system during an interview on October 26, 2015. [s. 30. (1) 1.]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response is made in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

On October 19, 2015, the Residents' Council Minutes for January 20th, 2015 up to September 15th, 2015, were reviewed by Inspector #592.

On July 14, 2015 Resident Council identified concerns related to staff yelling and disrupting Residents sleep.

On August 19, 2015 Resident Council requested to post a memo for night staff members to whisper between them and to put the volume of the radio down in the lounges.

On September 15, 2015 Resident Council recommended felt pads should be placed under chair legs to keep the floor in good state of repair and to facilitate movements of the chair along the floor. In addition, concerns were brought forward once again about staff yelling and disrupting Residents sleep.

On October 19, 2015, Inspector #592 interviewed the assistant of the Resident's Council who indicated that concerns brought forward by Resident Council are communicated verbally on the same day and resolved shortly by the affected department managers. She further told Inspector #592 that no written response related to these concerns were provided to the Resident Council as she was not aware that a written response was required.

On October 19, 2015, Inspector #592 interviewed the DOC who indicated that concerns are resolved when they are raised but was not aware that the home should provide a response in writing within 10 days of receiving the Residents' Council advice related to concerns or recommendations. [s. 57. (2)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with

respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The licensee has failed to ensure that the admission package include the home's policy to promote zero tolerance of abuse and neglect of residents.

On October 22, 2015 Inspector #545 reviewed the admission package to obtain the home's policy to promote zero tolerance of abuse and noted that the admission package did not contain this current policy.

Inspector #545 then interviewed the Director of Care, who indicated that the home had provided a summary of the home's policy titled :"La Politique de la Prevention et de L'Elimination de l'abus", instead of adding the Revera policy to their package. [s. 78. (2) (c)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of inspection reports from the past two years for the Long-Term care Home are posted in a conspicuous and easily accessible location.

On October 14, 2015 Inspector #545 conducted the initial tour in the home and noted that a binder was located at the front entrance to the home that contained copies of inspection reports, however the most current inspection reports were not there.

On October 21, 2015 Inspector #547 noted that the most recent inspection reports were located behind a locked glass cabinet near the main entrance of the home. This locked glass cabinet is not considered to be an easily accessible location for residents, families and friends of the home to access at all times.

Inspector #547 interviewed the DOC regarding the posted inspection reports in the home. The DOC indicated that the home posted in the locked wall cabinet the most recent reports to be more visual to residents and families, but did not take into consideration if this glass cabinet was easily accessible on evenings, nights or weekends when reception staff are not available. [s. 79. (1)]

WN #14: 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 ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

On October 14, 2015 Inspector #545 noted lingering offensive odours or urine in the hallways near three specified resident rooms. Inspector #547 also noted a lingering musty odour in spa rooms for Val des Roses, Pommeraie and Pinneraie units.

On October 15 and 16, 2015 the Inspection team continued to note lingering offensive odour in the hallway near another specified resident room.

On October 19, 2015 the Environmental Manager reported to Inspector #547 that the home currently does not have any formal process in place or any products to manage offensive odours. The Environmental manager indicated that the only room that he has been made aware of for odours was for one of these specified resident rooms.

Inspector #547 reviewed the second floor hallway area near a specified resident room, and lingering offensive odour of urine was noted as well as inside this resident's bedroom. PSW #140 indicated that the resident's room has odours all the time.

Inspector #547 and the Environmental Manager then noted the musty odour in the spa/tub rooms on Pommeraie and Pinneraie units during the Residents lunch period and it was observed that the floor grip strips inside the shower areas had a heavy build up of grey, orange matter. The Environmental Manager indicated that he was unsure if this odour came from these strips, or the drain, however confirmed there was an offensive odour in this space. The Spa/Tub room on the Vals des Roses unit was also observed, and the Environmental Manager noted a lingering offensive odour of urine.

On October 22, 2015 Inspector #547 noted lingering offensive odour of urine in a specified resident room and bathroom. Resident #031's daughter indicated to Inspector #547 during an interview this same day, that the reason she cleans the room so much is to try to eliminate this odour. [s. 87. (2) (d)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #014's personal items and clothing were labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing.

Resident #014 was admitted to the home with a large amount of clothing and blankets in large bags.

Resident #014 indicated to Inspector #545 that several personal clothing items were placed in large black garbage bags for labelling and two of the six bags were never brought back to him/her.

During a review of the Resident's health record, an inventory of personal items was not found, as per the home's Inventory and Labelling Policy (D-20-10).

On October 23, 2015 during an interview with Laundry Aide #136, she indicated that six large garbage bags of clothing had been delivered to the Laundry Room for labelling for Resident #014. She indicated that she labelled close to 70% of the items and when realized that the rest of the items were similar items, she contacted the Resident/Family Services Coordinator for advice, and it was decided that the rest of the items be left unlabelled in two black garbage bags in a different location in the basement of the home

until the Resident needed it. The Laundry Aide further indicated that the two black garbage bags went missing in the Spring and it was thought that they were sent for donation with the rest of the unlabelled clothing found in the home.

During an interview with the Resident/Family Services Coordinator, he indicated that Resident #014's clothing were not all labelled upon admission due to the large number of items the resident came in with. He indicated that two out of six bags were left unlabelled in the laundry room due to limited space in the Resident's room. The Resident/Family Services Coordinator further indicated that last March 2015, during the spring clean-up, Residents' unlabelled items from the lost and found were sent off for donation, and thinks that Resident #014's two bags of unlabelled clothing were possibly sent for donation at this same time. The Resident Services Coordinator further indicated that there is currently no process for updating the admission clothing inventory list and that clothes brought in by residents or families after admission often do not get labelled and many were lost. [s. 89. (1) (a) (ii)]

2. The licensee has failed to ensure that as part of the organized program of laundry services under clause 15(1)b of the Act, every licensee of a long-term care home shall ensure that the process to report and locate residents' lost clothing and personal items is implemented.

During interviews with the following Residents, lost items were reported to Inspectors #545 and #547:
-A specified resident- one pair of light blue pyjamas bottom, approximately one month ago
-A specified resident- three bras (white, pink and brown), two pair of pants (black & grey), approximately three weeks ago
-A specified resident- six blankets, three winter jackets, six new bras, several night gowns, dresses and skirts, last winter

All three Residents indicated that they had notified staff of personal items being lost and that staff had looked for the items however all items remain missing.

The home's policy: Marquise Hospitality: Personal Clothing Procedures Storage of Lost/Unclaimed Personal Clothing, Index I.D. ES D-20-30, revised January 21, 2015 was reviewed by the Inspector. On page 1 of the procedure:
- item 5. it is documented that "All lost clothing concerns of families or visitors are brought to the resident services coordinator or delegate.

- item 6. The resident services coordinator will complete a client service response or complete the Missing Clothing Checklist (page 2) and forward the response to the nursing and laundry departments.
- item 7. The nursing department will search the home area and laundry department will search the laundry for the missing clothing and report back to the resident service coordinator.

During interviews with PSW #129 and RPN #139, they indicated to Inspector #545 that an inventory list of clothing is to be completed at admission and sent with the Resident's clothes to the Laundry for labelling, then kept in the Residents' paper chart, however no clothing inventory lists were found for two of the above specified residents. PSW #129 and RPN #139 further indicated that they were not aware of the missing items for all three Residents. RPN #139 indicated that if a Resident reported a missing item, she would fill out a Lost & Found form, but was unable to find this form in the unit's filling cabinet.

During an interview with Laundry Aide #136, she indicated that if they find Residents' clothing unlabelled, they would automatically place the item in the lost & found areas. She indicated that she had not received a Lost & Found document for these three specified residents. She further indicated that when a lost clothing item is reported to staff, that they are suppose to complete a "notification de vetement egare" document, however she has not received these forms lately.

The Documentation Manager provided the Inspector with a form "Formulaire Réponse de Service aux Résidents" indicating that this was the document that staff were expected to complete when Residents reported missing items, including lost clothing. She also indicated that the green form (Notification de vêtement égaré) was no longer in use.

During an interview with the Resident/Family Services Coordinator, he indicated to Inspector #545 that it was the responsibility of the nursing staff to complete a Lost & Found form and that it is sent to the Laundry Department to be managed by the Environmental Services Manager. He indicated that most of the clothing that is reported is lost in transit, either placed in the wrong room or was unlabelled. He indicated that he was aware of 2 out 3 of the specified residents reporting lost laundry items. He further added that no Lost & Found forms were completed for any of the lost items for all three Residents.

The Resident/Family Services Coordinator indicated that staff were expected to fill out a

Lost & Found form but that he had not received one for missing clothing for a very long time. After checking his Policy & Procedure manual, he indicated that a Missing Clothing Checklist existed, however it had not yet been translated into French, therefore not yet in use. [s. 89. (1) (a) (iv)]

Issued on this 8th day of January, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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) :	LISA KLUKE (547), ANGELE ALBERT-RITCHIE (545), JOANNE HENRIE (550), MELANIE SARRAZIN (592)
Inspection No. / No de l'inspection :	2015_286547_0021
Log No. / Registre no:	O-002653-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 30, 2015
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	MONTFORT 705 Montreal Road, OTTAWA, ON, K1K-0M9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kelly Boisclair

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

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

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)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all registered nursing staff involved in medication administration use safe medication administration practises as per the home's policies and procedures .The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA s. 8 (1) (b) through the following actions:

1. Provide re-education to all registered nursing staff on the home's most current Medication Administration policies and procedures to ensure actions are taken to protect residents by reviewing the following:
- Medication administration management
- Narcotic and controlled drugs administration management
- Resident self-administration of medications management
- And the College of Nurses of Ontario Practice Standard related to Medication Administration

2. Develop and implement a process to ensure ongoing monitoring of the management of medication administration, storage of medications and resident self-administration of medications methods, in partnership with the home's pharmacist

This plan must be submitted in writing to Angèle Albert Ritchie, LTCH Inspector at 347 Preston St, unit 420, Ottawa, ON, K1S 3J4 or by fax (613) 569-9670 on or before December 7, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that Registered Nursing Staff in the home follow the home's policy and procedures from Revera regarding: Medication Administration, Management of Narcotic and Controlled Drugs and Self-Administration of Medication.

Regarding the Medication Administration and Management of Narcotic and Controlled Drugs policies:

On October 21, 2015 Inspector #545 observed the following medications (narcotic and controlled drugs) missing from their packaged blister packs in the locked drawer of the locked medication cart during a morning medication pass observation:
1) Narcotic medication for Resident #042 had 26 tablets left in blister pack, narcotic sheet indicated 28

2) Narcotic medication for Resident #043 had 19 tablets left in blister pack, narcotic sheet indicated 21
3) Narcotic medication for Resident #044 had 26 tablets left in blister pack, narcotic sheet indicated 28
4) Controlled drug for Resident #045 had 26 tablets left in blister pack, narcotic sheet indicated 28
5) Narcotic medication for Resident #046 had 26 tablets left in blister pack, narcotic sheet indicated 28
6) Narcotic medication for Resident #047 had 19 tablets left in blister pack, narcotic sheet indicated 21

Inspector #545 further observed these missing narcotic and controlled drugs pre-poured in medication cups in several Residents' unlocked bins in the single-locked medication cart.

During an interview with RPN #123, she indicated to Inspector #545 that when she had removed the 0800 dose earlier in the day, she had, by error, removed a second tablet from the packaged blister pack. She further indicated that she had administered one tablet prior to 08:00 then pre-poured a second tablet into a medication cup for the noon dose then placed each cup in the Resident's bins. RPN #123 indicated that it should not be a problem since she was the only Registered Nursing staff with the key to the Medication Cart.

The DOC indicated to Inspector #545 on October 21, 2015 that medications must remain in the original labelled container(s) or package(s) provided by the pharmacy service provider until administered to a resident and that all medications will not be prepared in advance (pre-poured) under any circumstances. The DOC further indicated that all narcotics and controlled drugs should be secured by double locking, at all times, and that all Registered Nursing staff had been informed to not leave narcotics outside of the double-locked narcotic storage area.

Upon review of the home's policy and procedure from Revera LTC-F-20 regarding the administration of Medications last revised August 2012 stated on page 1 of 3:
- #3.Medications must remain in the original labelled container(s) or package(s) provided by the pharmacy service provider or the Government supply until administered to a Resident.
- #6. Medications will not be prepared in advance (pre-poured) under any

circumstances.

Upon review of the home's policy and procedure from Revera LTC-F-80 regarding the Management of Narcotic and Controlled Drugs last revised August 2012 stated on page 1 of 3:
- #4. All narcotic and controlled drug(s) will be secured by double locking.

On October 21, 2015 Inspector #545 observed RPN #123 administer several medications to Resident #041 between 08:00 and 08:15. Out of these medications that was administered, a signature was not found when the Medication Administration Record (MAR) was reviewed by Inspector #545 at 08:45 this same day. Inspector #545 further noted that the medications (narcotic and controlled drugs) missing from their packaged blister packs as noted above were also not signed for after the morning medication administration.

Upon review of the home's policy and procedure from Revera LTC-F-20 regarding the Administration of Medications last revised August 2012 stated on page 2 of 3:
- #15. All medication administered, refused or omitted will be documented immediately after administration on the MAR/TAR using the proper codes by the administering nurse.

Regarding the Self Administration of Medication policy:

On October 15, 2015 and October 21, 2015 one large jar of prescribed cream was observed on the counter in the bathroom of Resident #035 by Inspector's #545 and #547. Resident #035 indicated to Inspector #545 that the resident applied this prescribed cream to self twice daily.

During an interview with PSW #124, she indicated to Inspector #545 that Resident #035 self-applied the prescribed cream twice daily and that it was kept in the resident's bathroom for easy access. RN #100 indicated that Resident #035 was admitted with the prescribed cream and that the resident was independent with the application. She further indicated that the prescribed cream was kept at the resident's bedside for easy access to apply twice daily.

The DOC indicated that all medications including prescribed creams that Residents can self-administer were to be stored in a locked bedside drawer in their rooms.

Upon review of the home's policy and procedure from Revera LTC-F-100 regarding Self Administration of Medication last revised August 2012 stated on page 2 of 3:
- #9. All medications will be stored in a locked bedside drawer/cabinet to which the Resident and Nurse will have the key.

It is noted that this area of non-compliance related to not following the home's policy and procedure regarding "Administration of Medications" was previously left as VPC for the 2014 RQI for this home.[s.8(1)b] (545)
(547)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
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 November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Kluke

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