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

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

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

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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
Aug 22, 2016	2016_276537_0029	020221-16	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Healthcare (CT) GPCO Ltd. as General Partner of Omni Healthcare (Country Terrace) Limited Partnership
161 Bay Street, Suite 2430 TD Canada Trust Tower TORONTO ON M5J 2S1

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

COUNTRY TERRACE
10072 Oxbow Drive R.R. #3 Komoka ON N0L 1R0

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

NANCY SINCLAIR (537), ALI NASSER (523), TERRI DALY (115)

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): July 11, 12, 13, 14, 15, 18, 19, 20, 21, and 22, 2016

The following intakes were completed within the RQI:

034192-15 - Follow up related to reporting and investigation of verbal and written complaints

008400-16/0907-000005-16 - Critical incident related to allegation of abuse to a resident
008669-16/0907-000004-16 - Critical incident related to allegation of abuse to a resident
012613-16/0907-000010-16 - Critical incident related to allegation of abuse to a resident
016391-16/0907-000011-16 - Critical incident related to allegation of abuse to a resident
019638-16/0907-000015-16 - Critical incident related to allegation of abuse to a resident
034837-15/0907-000024-15 - Critical incident related to an incident with injury to a resident
020211-16/0907-000016-16 - Critical incident related to an incident of suspected neglect towards a resident
010654-16/IL-4416-LO - Complaint related to allegations of falsifying of documents

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care(ADOC), Nutrition Manager, Life Enrichment Coordinator, Clinical Care Coordinator, Resident Assessment Instrument(RAI) Coordinator, Infection Control Nurse, Registered Dietitian, three Registered Nurses(RN), four Registered Practical Nurses(RPN), eleven Personal Support Workers(PSW), Residents' Council representative, residents and families.

The inspector(s) also conducted a tour of all resident areas and common areas, observed residents and care provided to them, observed meal service, medication passes, medication storage areas, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, training records, and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **8 WN(s)**
- **6 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 101. (1)	CO #001	2015_226192_0053	537

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

As per O.Reg 79/10, s.5, neglect is defined as 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.

A clinical record review for an identified resident revealed the following:

The resident was admitted to the home with a specific care intervention.
A test was ordered by the physician regarding the care intervention and was processed.
On receipt of the results of the test, the result was initialled by a registered staff member and placed in the chart without notifying the physician.
As a result, the resident had a change in condition.

Administrator #101 said in an interview that the resident had a test done. The test results were positive and a registered staff member received and initialled the lab results and put it in the chart without notifying the physician. As a result, the resident had a change in condition.

Administrator #101 said that she considered this to be a neglect of the resident and reported that registered staff members would be receiving additional education on the homes policy.

Administrator #101 said that the expectation was that the test results were followed up as per policy.

Resident had a positive test result that was not treated which resulted in the resident having a change in condition. There was actual harm to this resident as a result of the abnormal results not being reported to the physician by a registered staff member so that treatment could be initiated. The scope of this incident is isolated. There is no previous related non compliance history. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The home's policy titled "Pressure Ulcer and Wound Management - HLHS-SW-3.6", effective date January 2012, indicated that areas of altered skin integrity were to be assessed weekly and the assessment documented.

The Clinical Care Coordinator #107 was identified by the Administrator #101 to be the Wound Champion who completed weekly assessments on all residents who had altered skin integrity. The Clinical Care Coordinator #107 stated that weekly assessments were documented in med-e-care. The Clinical Care Coordinator #107 indicated that in the absence of the Clinical Care Coordinator/Wound Champion that it was expected that the registered staff who were working on the day of the scheduled assessment would complete the treatment and /or assessment as indicated in the treatment record and then document in med-e-care. The Clinical Care Coordinator #107 also stated that refusals of treatment should also be indicated in med-e-care.

An interview with the Clinical Care Coordinator #107 indicated that an identified resident was admitted to the home with identified skin integrity issues. Review of the electronic

treatment record (eTAR) revealed that the scheduled treatment for the skin integrity issues were not signed as being completed as ordered by a registered nurse. Review of med-e-care for the same day also did not include documentation of the assessment of this skin integrity issue.

The Clinical Care Coordinator/Wound Champion #107 stated that this should have been completed by a registered staff, which would include the treatment record identifying the staff who completed the assessment and accompanied by the assessment in med-e-care, or if the treatment was refused, the treatment record should indicate the treatment was not delivered and accompanying documentation in med-e-care of the refusal, and that neither was completed. The treatment record indicated that the treatment had been neither completed or refused.

B) Record review for an identified resident indicated that the resident had an identified skin integrity issue that required a treatment as ordered by the physician and weekly assessment and documentation in med-e-care.

Review of the eTAR revealed that the scheduled treatment for the identified skin integrity issue was not signed as being completed as ordered by a registered nurse. Review of med-e-care for the same day also did not include documentation of the assessment of this skin integrity issue.

The Clinical Care Coordinator/Wound Champion #107 stated that this should have been completed by a registered staff, which would include the treatment record identifying the staff who completed the assessment and accompanied by the assessment in med-e-care, or if the treatment was refused, the treatment record should indicate the treatment was not delivered and accompanying documentation in med-e-care of the refusal, and that neither was completed. The treatment record indicated that the treatment had been neither completed or refused.

The Administrator stated that the policy for the treatment of the identified skin integrity issues was not followed. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Clinical record review and interview with the Clinical Care Coordinator # 107 and Resident Assessment Instrument Coordinators/ RPNs #102, #106 and #107 revealed

that staff did not comply with a specific home policy regarding completion of assessments for four identified residents.

The scope of this incident is minimal harm or potential for actual harm. The severity is a pattern. There is related non compliance in this area. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place for skin and wound management is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A Critical Incident System Report(CIS) filed by the home, a review of the internal witness report and an interview with an identified PSW witness confirmed that a resident was provided care that was not consistent with the plan of care for the resident.

The licensee has failed to ensure that resident #014 was provided the care that was set out in the plan of care. [s. 6. (7)]

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 care set out in the place of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident had fallen, the resident had been assessed and a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Review of the clinical record for an identified resident revealed that the resident had fallen on two occasions. Review of the clinical record did not include a post fall assessment completed following the falls.

Registered Practical Nurse #119 stated during an interview that when a resident falls, part of the assessment was to complete a post-falls assessment, and this should be completed with each fall. It was indicated that this could be done electronically in the med-e-care documentation system or on a paper copy. A post-fall assessment in either form had not been completed for the falls on the identified dates.

The Administrator #101 stated that a post-fall assessment should be completed following all falls. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the resident has fallen, the resident is assessed and a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

A clinical record review for an identified resident with Clinical Care Coordinator # 107 and RAI RPN #111 revealed that the resident had a change in urinary continence.

A clinical record review for this resident with Clinical Care Coordinator # 107 and RAI RPN #111 revealed that although Urinary Continence Assessment(UCA) had been completed on other occasions, there was no documented evidence that a UCA had been completed on this occasion when a change in condition was determined that affected the continence of the resident.

Clinical Care Coordinator # 107 and RAI RPN #111 said that it was the home's expectation that an assessment would be completed to promote continence for every incontinent resident. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who is incontinent receives an assessment that Includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

Observations on July 11, 2016 at 1004 hours revealed that the tub room door on a specified resident care area was observed to be unlocked and unattended. Inside the tub room, there was an open cupboard which contained three bottles of Virox Cleaner and a bottle of Crew Cleaner. Residents were passing by this room returning from breakfast. PSW #130 confirmed the door was opened as well as the chemicals were accessible.

PSW #130 said that the home's expectation was to have the door locked and chemicals not accessible to residents. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances at the home are kept inaccessible to residents at all time, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Administrator #101 and RPN #102, who was identified as the Infection Prevention and Control Nurse said that staff are expected to participate in hand hygiene practice as part of the Infection Prevention and Control Program.

Observations on July 13, 2016 at 1020 hours, by the main nursing station revealed that a identified person was assessing residents in the main entrance by the nursing station, touching their arms, ankles, and using the same piece of equipment on multiple residents. This person had assessed four residents, and did not implement hand hygiene or clean equipment between residents.

Further observation revealed the identified person completed assessing twelve other residents, and continued that without implementing hand hygiene or cleaning the equipment between residents.

Inspector #523 asked RN #126 about the home's expectations of the Infection Prevention and Control (IPAC) practices when providing assessment or treatment to residents. RN #126 said that they need to wash their hands and clean multi-use equipment between residents. RN #126 witnessed with inspector #523, the home's IPAC practices not being followed by the identified person.

Infection Control RPN #102 stated that a conversation about the home's IPAC expectations, specifically hand hygiene and the cleaning of multi-use equipment, had been held with this person and this conversations was held again on July 13, 2016 and stated that the identified person confirmed an awareness of the expectation and felt they were unrealistic. The outcome of the conversation was documented on a Witness Report.

Administrator #101 said in an interview that this was a known concern to the home and that a discussion had occurred in regards to IPAC practices, wipes and direction for IPAC were previously provided. Administrator #101 said that this practice was not a proper implementation of IPAC measures done by the home. [s. 229. (4)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident were notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of neglect of the resident that had resulted in a physical injury or pain to the resident or that caused distress to the resident that could potentially be detrimental to the resident's health or well-being; and were notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A review of Critical Incident System Report (CIS) revealed that an identified resident had a change in health status.

The report also stated that a specific test had been ordered. The results were delivered to the home The results were initialled by a registered staff member, and placed in the resident's chart. The physician was not informed of the results. No orders were obtained for treatment.

The Administrator said that the resident had just died, the family was mourning the resident's death and in a period of grieving, and did not see that this was needed after death had occurred.

The inspector informed Administrator #101 that this was a suspected staff to resident neglect, the home had reported this CI as neglect, and the expectation would be to inform the SDM about any suspected neglect to the resident. [s. 97. (1)]

Issued on this 24th day of August, 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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NANCY SINCLAIR (537), ALI NASSER (523), TERRI DALY (115)
Inspection No. / No de l'inspection :	2016_276537_0029
Log No. / Registre no:	020221-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 22, 2016
Licensee / Titulaire de permis :	Omni Healthcare (CT) GPCO Ltd. as General Partner of Omni Healthcare (Country Terrace) Limited Partnership 161 Bay Street, Suite 2430, TD Canada Trust Tower, TORONTO, ON, M5J-2S1
LTC Home / Foyer de SLD :	COUNTRY TERRACE 10072 Oxbow Drive, R.R. #3, Komoka, ON, N0L-1R0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Karen Dann

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

To Omni Healthcare (CT) GPCO Ltd. as General Partner of Omni Healthcare (Country Terrace) Limited Partnership, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure that residents are not neglected by staff by ensuring:

1) All test results are checked by a registered staff.
2) Abnormal or critical results will be documented in the Progress Notes and the Doctor will be informed of the test results.
3) Test results will be checked by the Doctor before being placed in the resident chart.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

As per O.Reg 79/10, s.5, neglect is defined as 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.

A clinical record review for an identified resident revealed the following:

The resident was admitted to the home with a specific care intervention.
A test was ordered by the physician regarding the care intervention and was processed.
On receipt of the results of the test, the result was initialled by a registered staff member and placed in the chart without notifying the physician.
As a result, the resident had a change in condition.

Administrator #101 said in an interview that the resident had a test done. The

test results were positive and a registered staff member received and initialled the lab results and put it in the chart without notifying the physician. As a result, the resident had a change in condition.

Administrator #101 said that she considered this to be a neglect of the resident and reported that registered staff members would be receiving additional education on the homes policy.

Administrator #101 said that the expectation was that the test results were followed up as per policy.

Resident had a positive test result that was not treated which resulted in the resident having a change in condition. There was actual harm to this resident as a result of the abnormal results not being reported to the physician by a registered staff member so that treatment could be initiated. The scope of this incident is isolated. There is no previous related non compliance history. [s. 19. (1)]

(523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 staff comply with a specified policy of the home by ensuring that:

1) Assessments are completed for all residents with a specific care intervention.
2) Four identified residents will receive assessments as per the home's policy.

Grounds / Motifs :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Clinical record review and interview with the Clinical Care Coordinator # 107 and Resident Assessment Instrument Coordinators/ RPNs #102, #106 and #107 revealed that staff did not comply with a specific home policy regarding completion of assessments for four identified residents.

The scope of this incident is minimal harm or potential for actual harm. The severity is a pattern. There is related non compliance in this area. [s. 8. (1) (b)] (115)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 30, 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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing 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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 22nd day of August, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nancy Sinclair

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