Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Nov 16, 2017;	2017_482640_0013 (A1)	017984-17	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE HALTON HILLS
9 Lindsay Court Georgetown ON L7G 6G9

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

HEATHER PRESTON (640) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Home requested extension to Order dates as follows;

Order #001 regarding refrigerator - January 31, 2018
Order #002 regarding required education for programs - January 31, 2018
Order #003 regarding locking of the medication carts - January 2, 2018

Issued on this 16 day of November 2017 (A1)

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

Original report signed by the inspector.

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HEATHER PRESTON (640) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): August 8, 9, 10, 11, 14, 15, 16, 17, 22, 23, 24, 25, 28, 29 and 30, 2017, in conjunction with a complaint inspection #2017_482640_0014

During the inspection, the Long Term Care Homes Inspector toured the home, observed the provision of resident care, reviewed resident clinical records, personnel files, staff training records and relevant policies and procedures and interviewed residents, families and staff.

Non-compliance related to O. Reg 79/10, s. 8(1) (b), Falls Prevention Policy not complied with, has been issued in the Complaint Inspection Report #2017_482640_0014

During the course of the inspection, the inspector(s) spoke with residents, families, Resident Council, Family Council, Social Worker, Maintenance Manager, Registered Dietitian, Dietary Services Manager, Personal Support Workers, Registered Practical Nurse, Registered Nurses, Director of Care, Assistant Director of Care and the Administrator.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Admission and Discharge

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

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

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Safe and Secure Home

Skin and Wound Care

Snack Observation

Sufficient Staffing

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

23 WN(s)
14 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that complied with manufacturer's instructions for the storage of the drugs.

On a specified date in August 2017, in a medication room, the Long Term Care Homes (LTCH) Inspector found insulins that were not stored in the refrigerator that complied with manufacturer's instructions. The manufacturer's instructions for an identified insulin indicated that the insulin should be stored in a refrigerator between 2-8 degrees Celsius. If it freezes or overheats, discard it. The manufacturer's instruction for a second identified insulin indicated that the insulin should be stored in a refrigerator between 2 and 10 degrees Celsius. The manufacturer's instruction for a third identified insulin indicated that the insulin be stored in the refrigerator at 2-8 degrees Celsius. Do not freeze the insulin and do not use if the had not been kept in the refrigerator.
The home's policy titled "The Medication Storage", policy number 3-4, dated February 2017, indicated that medications requiring refrigeration should be stored in a refrigerator between 2-8 degrees Celsius.
LTCH Inspector reviewed the temperature log of the refrigerator in which the insulin was stored and found that the temperatures of the refrigerator to be above the required temperature on several identified dates in August 2017.
The high temperatures of the refrigerator were not reported to the management until the LTCH Inspector removed one of the insulin boxes and found the box was

wet. The ADOC indicated that the high temperatures should have been reported by staff when they first reached the high reading.
The DOC confirmed that the insulin should have been stored in a refrigerator with temperatures ranging between 2 and 8 degrees Celsius.
The licensee failed to ensure that drugs were stored in an area that complied with manufacturer's instructions. [s. 129. (1) (a)]

2. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was used exclusively for drugs and drug related supplies.

During stage one of the Resident Quality Inspection (RQI), LTCH Inspector #561 observed in resident #010's room, the resident's treatment on their night table. Registered staff #102 was interviewed and stated that specified treatments were to be kept at the nursing station. Review of the clinical records confirmed that the resident did not have an order to self- administer treatments and keep them in their room. Registered staff #102 confirmed this and stated that the treatment should have been stored at the nursing station.
The home's policy titled "Transfer of Function/Delegation of Tasks, policy number RC-16-01-06, revised February 2017, stated that the care staff were required to return the treatment to the nurse when treatment had been administered.
The ADOC was interviewed and confirmed that the treatment should have been returned to the registered staff after administration and stored in the medication cart. [s. 129. (1) (a)]

3. The licensee failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

An unlocked medication cart was observed by the LTCH Inspector, with no staff present. Several residents were observed seated in the lounge. During an interview, RPN #133 reported the expectation was for the cart to be locked when unattended and confirmed the cart was unlocked and unattended. (585) [s. 129. (1) (a) (iii)]

4. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

During observation of a morning medication pass, LTCH Inspector observed the medication cart and noticed that a number of sleeves containing controlled

substances on a ring which were not stored in the separate narcotic bin which was double locked. The controlled substances were found outside of the narcotic bin in the bottom drawer of the medication cart. Registered staff #110 confirmed the medications should have been double locked and kept in the narcotic bin.
The home's policy titled "Management of Narcotic and Controlled Drugs", policy number RC-16-01-13, revised February 2017, indicated that all controlled substances were to be stored in a separate, double locked area within the locked medication cart.
The ADOC confirmed that all controlled substances were required to be stored in a locked narcotic bin in a locked medication cart.
The licensee failed to ensure that controlled substances were stored in a locked area within the locked medication cart. [s. 129. (1) (b)]

Additional Required Actions:

CO # - 001, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001,003

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that for purposes of paragraph 6 of subsection 76 (7) of the Act, the following were other areas in which training shall be provided to all staff who provided direct care to residents; 1. Falls prevention and management.

During a complaint inspection, the Long-Term Care Homes (LTCH) Inspector was

required to review additional training for direct care staff related to fall prevention and management as a result of non-compliance. The LTCH Inspector interviewed the Director of Care (DOC) who informed the LTCH Inspector that for the year 2016, 89 percent of all direct care staff had been trained on falls prevention and management.
The licensee failed to ensure that all direct care staff were trained in falls prevention and management. [s. 221. (1) 1.]

2. The licensee failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following were other areas in which training shall be provided to all staff who provide direct care to residents: 2. Skin and wound care.

The home provided documentation that not all staff, who provided direct care to residents in 2016, received training in the area of skin and wound care.
The DOC and ADOC were interviewed and confirmed that training was offered in the home in 2016, related to wound and skin care; however, only 63 percent of staff who provide direct care to residents participated in the required training.
The home did not ensure that all direct care staff received the required wound and skin care training annually. [s. 221. (1) 2.]

3. The licensee failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following were other areas in which training shall be provided to all staff who provide direct care to residents: 3. Continence care and bowel management.

The home provided documentation that not all staff, who provided direct care to residents in 2016, received training in the area of continence care and bowel management.
The ADOC was interviewed and confirmed that training was offered in the home in 2016, related to continence care and bowel management; however, only 54 percent of staff participated in the required training.
The home did not ensure that all direct care staff received the required continence care and bowel management training annually. [s. 221. (1) 3.]

4.The licensee failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following were other areas in which training shall be provided to all staff who provide direct care to residents: 4. Pain management, including pain recognition of specific and non-specific signs of pain.

The home provided documentation that not all staff, who provided direct care to residents in 2016, received additional training in the area of pain management.
The ADOC was interviewed and confirmed that additional training was offered in the home in 2016, related to pain management; however, only 45 percent of staff participated in the required additional training.
The home did not ensure that all direct care staff received the required additional training related to pain management. [s. 221. (1) 4.]

5. The licensee failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following were other areas in which training shall be provided to all staff who provide direct care to residents: 5. For staff who apply physical devices or who monitor residents restrained by a physical device.

The home provided documentation that not all staff, who provided direct care to residents in 2016, received training in the area of application of the physical devices or monitoring of residents restrained by a physical device.
The ADOC was interviewed and confirmed that training was offered in the home in 2016, related to restraints; however, only 53 percent of staff participated in the required training.
The home did not ensure that all direct care staff received the required training annually related to the application of physical devices. [s. 221. (1) 5.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

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

Specifically failed to comply with the following:

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

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Resident #030 was observed on two specified dates in August 2017, in a wheelchair and an identified safety device in place.
The clinical record was reviewed and there was no safety device identified in the plan of care.
RPN #105 was interviewed and confirmed they would be expected to include it in the plan of care.
The ADOC was interviewed and confirmed it was expected that staff document the resident's needs and preferences on the plan of care.
The home failed to ensure that the plan of care for resident #030 was based on an assessment and the needs and preferences of the resident. [s. 6. (2)]

2. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute

decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record of resident #061 as a result of a complaint. The clinical record noted the physician completed a medication review. The physician ordered a medication to be initiated. The home's policy Physician/Nurse Practitioner Orders, policy #RC-16-01-04 and revised February 2017, directed staff to obtain consent for the newly prescribed product. Interview with RN #102 and RPN #108, who both informed the LTCH Inspector they had not received consent from the substitute decision-maker. During an interview with the Director of Care (DOC), they confirmed that consent was required prior to the initiation of any new medication and that had not occurred in this case. [s. 6. (5)]

3. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

As a result of a complaint inspection related to resident #045, the clinical record was reviewed by the LTCH Inspector. The clinical record indicated there was no discussion with the resident regarding the implementation of the specified equipment. The resident's substitute decision-maker (SDM) noted they had not been contacted regarding the implementation of the specified equipment.
On a specified date in January 2017, RN #145, restricted the resident's movement without consent. During an interview, RN #145 confirmed they had restricted the movement of resident #045 without their consent or the consent of the resident's substitute decision - maker. The RN confirmed there was no opportunity afforded the resident or the SDM to participate in the implementation of restricting the resident's movement. [s. 6. (5)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs changed or care set out in the plan was no longer necessary.

During inspection of specified treatment for resident #026, the LTCH Inspector reviewed the written plan of care. The written plan of care directed staff to administer a specified treatment four times daily (QID). Review of the Medication

Administration record (MAR), directed staff to administer a different prescribed treatment four times daily. The resident was receiving the different treatment four times per day as per the MAR.
During an interview with RAI Coordinator #125, they confirmed the written plan of care was not revised based on the assessment of the resident when the care set out in the plan was no longer necessary. [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;
i) the plan of care is based on an assessment of the resident and the needs and preferences of that resident
ii) the resident or the resident's substitute decision maker are given an opportunity to participate fully in the development of the resident's plan of care and
iii) that the care set out in the plan 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. 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. Where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system was (a) in compliance with and was implemented in accordance with all applicable requirements under the Act.

In accordance with Regulation, s.48, required the licensee to ensure that the interdisciplinary programs including pain management program were developed and implemented in the home and each program must, in addition to meeting the requirements set out in section 30, provide for screening protocols; and provide for assessment and reassessment instruments. O. Reg. 79/10, s.48

Regulation 52(2) directed the licensee to ensure that when a resident's pain was not relieved by initial interventions; the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose. The LTCH Inspector reviewed the home's Pain Management, Resident Care Quality Indicators, policy reference #RESI-10-03-1, version 2014. The policy did not direct staff to complete a clinically appropriate assessment instrument specifically designed for the assessment of pain when initial interventions to relieve pain were not effective.
During an interview with the Director of Care (DOC), they confirmed the licensee's pain management policy did not direct staff to complete the pain assessment when initial interventions did not relieve the resident's pain. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, was complied with.

The home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, Appendix 1", policy number RC-02-01-02, last updated April 2017, indicated that the reporting requirements were that any person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in a risk of harm to the resident must be immediately reported to the Ministry of Health and Long Term Care.

On a specified date in August 2017, PSW #123 reported to the LTCH Inspector they had observed a private care giver of resident #008 physically holding the resident down. The PSW indicated they reported it to the registered staff immediately. During the interview the PSW indicated that they believed this was abuse.
The LTCH Inspector interviewed the DOC to find out if they had received a report of this incident and what steps were taken by the home. The DOC stated that they had received the report of the incident. The home did not report this allegation to

the Director.
The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with when an allegation of abuse was reported and the incident was not reported to the Director. [s. 20. (1)]

2. The licensee failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

On a specified date in January 2017, resident #045 had their movement restricted by RN #145.
The home's policy "Mandatory and Critical Incident Reporting (ON), policy #RC-09-01-06, last revised April 2017, directed staff to immediately report an incident to the Director where improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident occurred. The policy directed staff, when completing the Critical Incident (CI) report, to include the names of any staff members or other persons who were present at or discovered the incident. The CI report was submitted to the Director without including all the names of any staff or other persons who were present. A PSW who assisted the RN in restricting the movement of resident #045 was not named in the report. Under analysis and follow up, the home noted that investigation was under way. Review of the ltchomes.net and interview of the Director of Care (DOC) and the Administrator, who confirmed there was no amendment submitted for this CI report as required. The policy directed the home to amend the Critical Incident report with new or additional information as it became available. [s. 20. (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 the licensee is to ensure there is a written policy to promote zero tolerance of abuse and neglect of residents, and ensure the policy is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to ensure (b) that the policy to minimize the restraining of residents was complied with.

As a result of a complaint inspection for resident #045, the clinical record was reviewed by the LTCH Inspector.
The home's policy "Least Restraints", policy # RC-22-01-01 and revised February 2017, directed staff that certain equipment was approved for use.
On a specified date in January 2017, RN #145, used unapproved equipment to restrict the movement of resident #045. During an interview with RN #145 they confirmed the use of unapproved equipment.
During an interview with the DOC, they told the LTCH Inspector that the equipment put in place to restrict the resident's movement were not approved as per the home's policy. [s. 29. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home's policy to minimize the restraining of residents is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident of the home was restrained, in any way, for the convenience of the licensee or staff.

As a result of a complaint inspection related to resident #045, the clinical record was reviewed by the LTCH Inspector.
On an identified date in January 2017, RN #145 documented in the clinical record that the resident had declined.
On an identified date in January 2017, RN #145, restricted the resident's movement without consent. The RN stated that would keep the resident safe from falling. During the same interview, RN #145 confirmed they had implemented an object to prevent the resident from moving. The RN stated they had not attempted to call for assistance from other departments, units or management to assist with resident #045.
During an interview with the DOC, they told the LTCH Inspector it was an expectation of the home that the RN reassign staff to provide one to one care for resident #045 and the actions taken were unacceptable. [s. 30. (1) 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 no resident of the home is restrained, in any way, for the convenience of the licensee or staff, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 35. Prohibited devices that limit movement
Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident; or
(b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement. 2007, c. 8, s. 35.

Findings/Faits saillants :

1. The licensee failed to ensure that no device provided for in the regulations was used on a resident, (b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement.

As a result of a complaint inspection related to resident #045, the clinical record was reviewed by the LTCH Inspector.
On a specified date in January 2017, RN #145, used equipment meant to assist with the activities of daily living to restrict the movement of resident #045. The RN confirmed the use of the equipment did inhibit the resident's freedom of movement.

During an interview with the DOC, they told the LTCH Inspector it was an expectation of the home that the use of an identified object to prevent the resident's freedom of movement was unacceptable. [s. 35. (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 no device provided for in the regulations is used on a resident to assist a resident with a routine activity of daily living, if the device has the effect of limiting or inhibiting the resident's freedom of movement, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that, (b) a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (ii) received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Resident #036 had altered skin integrity.
The clinical record was reviewed and there were no interventions identified related to the altered skin integrity.
The resident was interviewed and they indicated that previously they had certain interventions.
RPN #105 and PSW #115 were interviewed and confirmed the resident had altered skin integrity. Both were unsure of any other preventative interventions that were implemented for the resident.
The ADOC confirmed there was only one identified intervention on the plan of care and other measures were expected to have been included and implemented in resident #036's plan of care.
The home failed to provide immediate interventions related to resident #036's altered skin integrity. [s. 50. (2) (b) (ii)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (ii) receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

During the RQI inspection process, the LTCH Inspector reviewed resident #020's clinical record. According to the resident's Medication Administration Record (MAR), they were receiving treatment for pain.
Review of the clinical record identified there was no clinically appropriate assessment instrument specifically designed for the assessment of pain completed during the months when treatment was being administered.
During interviews with RPN #104 and #106, they told the LTCH Inspector the clinically appropriate assessment tool was used only in certain circumstances.
During an interview with the DOC, they confirmed it was an expectation that a pain assessment be completed using the home's clinically appropriate assessment instrument specifically designed for the assessment of pain. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system at a minimum, provided for preparation of all menu items according to the planned menu.

A) On an identified date in August 2017, beef barley soup was on the planned menu for lunch. During a meal observation resident #054 reported the beef barley soup was bad and identified there was no beef in it. Review of the recipe for beef barley soup identified beef stew meat was a listed ingredient in the recipe. Interview with dietary staff #136 who prepared the soup, reported a beef stock was used; however, no beef was in the soup. Interview with the Food Service Manager who confirmed beef was available in the fridge and should have been included as part of the recipe. Dietary staff #136 confirmed the menu item was not prepared according to the planned menu. [s. 72. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the food production system at a minimum, provide for preparation of all menu items according to the planned menu, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had a dining and snack service that included food and fluids being served at a temperature that was both safe and palatable to the residents.

Residents #013, #020 and #039 reported in interviews that hot foods were not always served hot.
The home's policy, "Temperatures of Food at Point of Service – NC-07-01-03", last updated November 2016, stated staff shall serve food and beverages to each resident at a temperature and in a manner that promotes comfort and safety. Take the holding temperature of foods just before serving to ensure that hot foods are served to residents at a minimum of 60 degrees Celsius (°C).

A) On an identified date in August 2017, chicken fingers and mashed potatoes were identified as hot menu items for lunch.

i) During a meal service in dining room A, hot menu items were probed and recorded at the following temperatures:
- Chicken strips: pureed texture 56°C, minced texture 47°C, regular texture 45°C
- Potatoes: minced texture 54°C, regular texture 36°C.
Two residents in the dining room reported their regular texture chicken fingers were not hot enough.

ii) During meal service in dining room B, hot menu items were probed and recorded at the following temperatures:
- Chicken strips: regular texture 47°C
Interview with dietary staff #137 who reported the record food temperatures between 1130 to 1200 hours, and meal time on the home area was at 1240 hours.

B) On an identified date in August 2017, western omelette and glazed carrots were identified as hot menu items for lunch.
i) During a meal service in dining room C, hot menu items were probed and recorded at the following temperatures:
- puree carrot: puree texture 44°C regular texture 43°C.
A lunch tray with a western omelette was served to resident #039. The item was probed and recorded at 52.6°C.

Interview with the FSM who confirmed the home's expectation was hot foods be served at a minimum of 60°C and confirmed the policy identified holding temperatures were to be taken just before serving to ensure hot foods were served at a minimum of 60°C. [s. 73. (1) 6.]

2. The licensee failed to ensure that the home had a dining and snack service that

included, at a minimum, course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

On an identified date in August 2017, in dining room D, residents #012, #057, #058 and #058 were observed with their main course in front of them, with dessert also served. Review of the dietary kardex did not identify the residents were to receive courses simultaneously. Interview with PSW #146 confirmed the four residents should have received their meal course by course. (585) [s. 73. (1) 8.]

3. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, the proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

i) On an identified date in August 2017, during nourishment pass in the afternoon, resident #056 was observed in bed with the head of their bed partially inclined. The resident was sliding and was not upright to drink. PSW #138 was observed standing while providing assistance.
Interview with the Registered Dietitian (RD) confirmed the resident was to be in an upright position when receiving food and fluid and staff were to be seated when assisting the resident.
ii) On an identified date in August 2017, during breakfast meal service in dining room D, resident #060 was observed in an identified position.
Interview with PSW #170 confirmed the resident was in an unsafe position for eating. Review of the plan of care directed staff on the proper positioning for the resident.
Interview with the ADOC confirmed the resident was not seated appropriately when receiving assistance with eating. [s. 73. (1) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home has a dining and snack service that includes food and fluids are served at a temperature that is both safe and palatable to residents, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that where an incident occurred that caused an injury to a resident for which the resident was taken to a hospital, but the licensee was unable to determine within one business day whether the injury had resulted in a significant change in the resident's health condition the licensee shall, (a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury had resulted in a significant change in the resident's health condition; and (b) where the licensee determined that the injury had resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident and follow with the report required under subsection (4).

As a result of a complaint inspection, the LTCH Inspector reviewed the clinical record and the Critical Incident Report for resident #050. On an identified date in December 2016, resident #045 was found to have a change in health condition. Two days later the resident was identified to have a significant change in health condition as a result. The home notified the Director three days after the discovery.

During an interview with the DOC, they informed the LTCH Inspector the report to the Director was submitted late and should have been sent two days earlier. [s. 107. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury resulted in a significant change in the resident's health condition the licensee shall, (b) where the licensee determines that the injury resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident and follow with the report required under subsection (4), to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions.

On an identified date in August 2017, resident #048 was observed in their wheelchair with the physical device incorrectly applied.
The LTCH Inspector interviewed PSW #109 and confirmed the physical device was incorrectly applied.
Interview with Registered staff #108 confirmed that the physical device used for resident #048 should have been applied correctly and according to the manufacturer's instructions.
The DOC was interviewed and stated that the physical device should have been applied in a specific way. The home did not keep manufacturer's instructions for any devices. The Administrator confirmed that the home did not keep the manufacturer's instructions for any wheelchairs or devices.
The licensee failed to ensure that the physical device was applied in accordance with the manufacturer's instructions. [s. 110. (1) 1.]

2. The licensee failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions.

On an identified date in August 2017, resident #033 was observed seated in their wheelchair with a physical device applied. The resident appeared to be sliding in their seat and tension was noted between the resident's body and the physical device. Long-Term Care Homes (LTCH) Inspector #585 requested staff reposition the resident to an upright position. PSW #148 confirmed the physical device was applied incorrectly and it was the expectation of the home that it be applied correctly.
Interview with the ADOC confirmed the physical device was not applied in accordance with the manufacturer's instructions. (585) [s. 110. (1) 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 the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

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

On an identified date in August 2017, LTCH Inspector was to check the narcotic bins that stored all narcotics to be disposed of. The DOC was the only person with a key to the narcotic bins. The ADOC was designated by the DOC to take the key and show the bins to LTCH Inspector. The keys to the bins were being kept in the DOC's office which was on the second floor of the home. The door to the DOC's office was unlocked, the key to the narcotic bin was stored on a shelf in the office. The ADOC stated that the door to the office should have been locked. Anyone could have access to the keys since the door was unlocked. The DOC confirmed that the office door should have been locked to ensure that no one had access to the keys.
The licensee failed to ensure all areas where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator. [s. 130. 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

As a result of a stage 1, the LTCH Inspector reviewed the clinical record for resident #020. The Medication Administration Record (MAR) for the month of May 2017, did not include any as needed (PRN) medications for resident #020. On an identified date in May 2017, the progress notes indicated that a prn medication was administered to resident #020.
During an interview with the Director of Care, they confirmed with the LTCH Inspector that the medication administered on an identified date in May 2017, was not prescribed for resident #020 and should not have been administered. [s. 131. (1)]

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

As a result of a stage 1, the Long Term Care Home (LTCH) Inspector reviewed the clinical record for resident #020. During the review of resident's medication administration record (MAR) for the months of May, June, July and August 2017, the LTCH Inspector identified two occasions where a medication was given which was not in accordance with the prescriber's directions. The medication order was written to be given once a day. The medication was administered twice daily on both noted occasions.
During an interview with the Director of Care (DOC), they informed the LTCH Inspector it was expected that the physician's order be followed as directed. Both occasions the medication was not administered in accordance with the directions. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure;
1) that no drug is used by or administered to a resident in the home unless the drug is prescribed for the resident
2) that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to report to the Director the results of every investigation undertaken under clause (1)(b).

As a result of a complaint inspection related to resident #045, the clinical record was reviewed by the LTCH Inspector.
On an identified date in January 2017, RN #145, restricted the free movement of resident #045 without consent. The home began their investigation of the complaint on an identified date in January 2017 and completed their investigation several days later. The home did not amend the Critical Incident Report with the results of the investigation.
During an interview with the Administrator and DOC, they told the LTCH Inspector the home had not amended the Critical Incident report following their investigation. [s. 23. (2)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #042 had a significant change in health status on an identified date in April 2017.
The clinical record was reviewed and the safety checks every 30 to 60 minutes was included in the plan of care. The LTCH Inspector #527 was unable to identify any documents that would indicate that the safety checks were conducted for resident #042.
PSW #134 was interviewed and indicated that if the resident had safety checks every 30 to 60 minutes, that they were expected to visualize the resident and ensure that they were safe, then document in Point of Care (POC) that they completed the checks.
The DOC was interviewed and confirmed the PSWs were expected to document their safety checks in POC when they were completed. [s. 30. (2)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received individualized personal care, including hygiene care and grooming on a daily basis.

During stage 1 of the RQI process, resident #025 triggered for being unshaven as per their customary routine. During an interview with the resident's Substitute Decision Maker (SDM), they told the LTCH Inspector the resident preferred to be shaved daily and this had not been the case. The resident's written plan of care did not include a preference for shaving however, the policy Daily Personal Care and Grooming, policy #RC-06-01-01 and revised April 2017, directed staff to provide daily facial shaving during AM care as defined by "morning care provided when the resident awakens for the day".
The LTCH Inspector observed the resident on three identified dates in August 2017, and the resident was not clean shaven.
During an interview with PSWs #115 and #129, they informed the LTCH Inspector that on the three dates, the resident had not been shaved. The PSWs informed the LTCH Inspector they had not attempted to shave the resident on those dates.
RPN #127 and #130 confirmed that resident #025 was not shaved and they should have been.
The DOC told the LTCH Inspector it was an expectation that all residents are to be shaved daily unless their individualized plan of care directed staff otherwise. [s. 32.]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During Stage 1 of the Resident Quality Inspection process, resident #017 was observed to have unclean hair. During further observations on two identified dates in August 2017, the resident's hair was unclean. After review of the clinical record by the Long Term Care Home (LTCH) Inspector, the resident's bath days and their preferred method of bathing were identified.
During an interview with Personal Support Worker (PSW) #111, they informed the LTCH Inspector that on each bath day, the staff usually wash the resident's hair. In this case the PSW had not provided the resident's preferred method of bathing on both identified bath days and did not wash the resident's hair.
Interview with Registered Practical Nurse (RPN) #112 revealed the PSW had not informed them of the change in method of bathing resident #017. They explained it was an expectation that PSWs inform the registered staff prior to changing the method of bathing a resident and this had not been done.
During an interview with the Director of Care (DOC), they told the LTCH Inspector it was the expectation that residents were bathed by the method of their choice.
Resident #017 had not been bathed by the method of their choice. [s. 33. (1)]

WN #21: The Licensee has failed to comply with LTCHA, 2007, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee failed to take into account the assessments and information under subsection 43 (6), and approve the applicant's admission to the home unless: (a) the home lacked the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances existed which were provided for in the regulations as being a ground for withholding approval.

As a result of a complaint inspection related to refusal of admission of applicant #052, the LTCH Inspector reviewed the admission application, refusal letter and notes made by the home. The application for admission was reviewed by the home on an identified date in January 2017 and a letter of refusal to admit to the home was sent to the family member of the applicant. Included in the rationale for refusing to admit, was that the applicant had specific health concerns and the home was ill equipped to deal with them.
During an interview with the home's Social Worker(SW) and the Director of Care (DOC), the LTCH Inspector was informed the home had a list of medical conditions whereby the home could refuse admission. The SW and the DOC confirmed the home has on-site support staff to assist with the management of the specific health condition which indicated the home had the ability to provide care to resident.
As a result of refusal to admit applicant #052, the home failed to take into account the resident's assessments and information and approve the applicant's admission to the home. [s. 44. (7)]

WN #22: 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 failed to ensure that, (a) each resident who was incontinent received an assessment that included 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 required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Resident #031 was admitted to the home on an identified date in February 2017, and the 24 hour care planning assessment was completed and identified that the resident was continent for bladder. On an identified date in February 2017, the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessed the resident's bladder continence as usually continent, and subsequently the quarterly RAI-MDS assessment identified the resident's continence as deteriorated to occasionally incontinent for bladder. In addition, the resident was hospitalized and was returned to the home on an identified date in August 2017 with further decline in bladder continence.
The home's policy called "Continence Management Program", reference number: RESI-10-04-01, and dated November 2013, directed staff to complete a continence assessment using a clinically appropriate assessment tool that was specifically designed for assessing continence when the resident had any deterioration in continence level and with any change in condition that may affect bladder continence.
RPN #105 and the RAI-MDS Coordinator were interviewed and confirmed that they were expected to complete a bladder assessment using the clinically appropriate tool designed for assessing continence when the resident's bladder continence had changed and with a change in condition. The RPNs indicated that the assessments were not completed as expected.
The home failed to ensure that resident #031 had a continence assessment using a clinically appropriate assessment instrument specifically designed for assessment of continence when the resident's condition changed and when there was a change in the resident's continence level. [s. 51. (2) (a)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the planned menu items were offered and available at each meal and snack.

A) On an identified date in August 2017, diet peach drink and texture modified cookie were on the planned menu for afternoon snack. During an observation of the snack pass on home area A, regular apple juice was provided to residents and texture modified cookie was not on the cart, as confirmed by PSW #138.
Resident #017 received texture modified cookie and apple juice and resident #062 received apple juice. PSW # 138 confirmed the residents required texture modified foods were not offered texture modified cookie. Interview with the FSM confirmed diet peach drink and texture modified cookie should have been offered and available as per the planned menu.

B) On an identified date in August 2017, diet tropical fruit drink was on the planned menu for afternoon snack, as reported by the FSM. During an observation of the snack pass on the home area B, diet peach drink was served, as confirmed by PSW #148. Interview with the FSM who confirmed diet tropical fruit drink should have been offered to the residents as per the planned menu. [s. 71. (4)]

Issued on this 16 day of November 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : HEATHER PRESTON (640) - (A1)

Inspection No. / No de l'inspection : 2017_482640_0013 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 017984-17 (A1)

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

Report Date(s) / Date(s) du Rapport : Nov 16, 2017;(A1)

Licensee / Titulaire de permis :
EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700,
MARKHAM, ON, L3R-9W2

LTC Home / Foyer de SLD :
EXTENDICARE HALTON HILLS
9 Lindsay Court, Georgetown, ON, L7G-6G9

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Emily Bosma

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To EXTENDICARE (CANADA) INC., 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 :

O.Reg 79/10, s. 129. (1) Every licensee of a long-term care home shall ensure that,

(a) drugs are stored in an area or a medication cart,

(i) that is used exclusively for drugs and drug-related supplies,

(ii) that is secure and locked,

(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and

(iv) that complies with manufacturer's instructions for the storage of the drugs; and

(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Order / Ordre :

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

1) The licensee is to ensure the refrigerator used to store any insulin is in good working order with the ability to maintain the temperature between 2 and 8 degrees Celsius.
2) The licensee is to ensure that the medication storage refrigerator temperature logs be audited to ensure compliance of the temperature range.
3) The licensee is to provide training to all registered staff regarding the requirement to check the refrigerator temperatures and the acceptable temperature range.
4) The licensee is to develop a process to direct staff as to the actions necessary when the medication refrigerator temperatures fall below the required range.
5) The licensee is to provide training to all registered staff related to the process to follow when the medication refrigerator temperatures are outside the required range.

Ontario

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The non-compliance was issued as a compliance order (CO) due to a severity level of minimal harm or potential for actual harm (2), a scope of pattern(2) and a compliance history in the last three years of "one or more related non-compliance in the last three (full) years" (3) in keeping with s.299(1) of the Regulation.

The licensee has failed to ensure that drugs were stored in an area or a medication cart that complied with manufacturer's instructions for the storage of the drugs.

On a specified date in August 2017, in a medication room, the Long Term Care Homes (LTCH) Inspector found insulins that were not stored in the refrigerator that complied with manufacturer's instructions. The manufacturer's instructions for an identified insulin indicated that the insulin should be stored in a refrigerator between 2-8 degrees Celsius. If it freezes or overheats, discard it. The manufacturer's instruction for a second identified insulin indicated that the insulin should be stored in a refrigerator between 2 and 10 degrees Celsius. The manufacturer's instruction for a third identified insulin indicated that the insulin be stored in the refrigerator at 2-8 degrees Celsius. Do not freeze the insulin and do not use if the had not been kept in the refrigerator.
The home's policy titled "The Medication Storage", policy number 3-4, dated February 2017, indicated that medications requiring refrigeration should be stored in a refrigerator between 2-8 degrees Celsius.
LTCH Inspector reviewed the temperature log of the refrigerator in which the insulin was stored and found that the temperatures of the refrigerator to be above the required temperature on several identified dates in August 2017.
The high temperatures of the refrigerator were not reported to the management until the LTCH Inspector removed one of the insulin boxes and found the box was wet.
The ADOC indicated that the high temperatures should have been reported by staff when they first reached the high reading.
The DOC confirmed that the insulin should have been stored in a refrigerator with temperatures ranging between 2 and 8 degrees Celsius.
The licensee failed to ensure that drugs were stored in an area that complied with manufacturer's instructions. [s. 129. (1) (a)]
(561)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Jan 31, 2018(A1)

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. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee shall ensure that all direct care staff receive training on the following;

1. Falls Prevention and Management
2. Skin and Wound Care
3. Continence Care and Bowel Management
4. Pain Management, including recognition of specific and non-specific signs of pain, and

Shall ensure that all direct care staff who apply physical devices or who monitor residents restrained by physical devices, receive training in the application, use and potential dangers of these physical devices.

Grounds / Motifs :

1. The licensee failed to ensure that for purposes of paragraph 6 of subsection 76 (7) of the Act, the following were other areas in which training shall be provided to all staff who provided direct care to residents; 1. Falls prevention and management.

During a complaint inspection, the Long-Term Care Homes (LTCH) Inspector was required to review additional training for direct care staff related to fall prevention and management as a result of non-compliance. The LTCH Inspector interviewed the Director of Care (DOC) who informed the LTCH Inspector that for the year 2016, 89 percent of all direct care staff had been trained on falls prevention and management. The licensee failed to ensure that all direct care staff were trained in falls prevention and management. [s. 221. (1) 1.]
(640)

2. The non-compliance was issued as a compliance order (CO) due to a severity level of minimal risk (1), a scope of widespread (3) and a compliance history in the last three years of "ongoing non-compliance despite previous action taken by the MOHLTC" (4) in keeping with s.299(1) of the Regulation.

The licensee failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following were other areas in which training shall be provided to all staff who provide direct care to residents: 2. Skin and wound care.

The home provided documentation that not all staff, who provided direct care to residents in 2016, received training in the area of skin and wound care.
The DOC and ADOC were interviewed and confirmed that training was offered in the home in 2016, related to wound and skin care; however, only 63 percent of staff who provide direct care to residents participated in the required training.
The home did not ensure that all direct care staff received the required wound and skin care training annually. [s. 221. (1) 2.]
(527)

3. The licensee failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following were other areas in which training shall be provided to all staff who provide direct care to residents: 3. Continence care and bowel management.

The home provided documentation that not all staff, who provided direct care to residents in 2016, received training in the area of continence care and bowel management.
The ADOC was interviewed and confirmed that training was offered in the home in 2016, related to continence care and bowel management; however, only 54 percent of staff participated in the required training.
The home did not ensure that all direct care staff received the required continence care and bowel management training annually. [s. 221. (1) 3.]
(527)

4. The licensee failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following were other areas in which training shall be provided to all staff who provide direct care to residents: 4. Pain management, including pain recognition of specific and non-specific signs of pain.

The home provided documentation that not all staff, who provided direct care to residents in 2016, received additional training in the area of pain management.
The ADOC was interviewed and confirmed that additional training was offered in the home in 2016, related to pain management; however, only 45 percent of staff participated in the required additional training.
The home did not ensure that all direct care staff received the required additional training related to pain management. [s. 221. (1) 4.]

(640)

5. The licensee failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following were other areas in which training shall be provided to all staff who provide direct care to residents: 5. For staff who apply physical devices or who monitor residents restrained by a physical device.

The home provided documentation that not all staff, who provided direct care to residents in 2016, received training in the area of application of the physical devices or monitoring of residents restrained by a physical device.
The ADOC was interviewed and confirmed that training was offered in the home in 2016, related to restraints; however, only 53 percent of staff participated in the required training.
The home did not ensure that all direct care staff received the required training annually related to the application of physical devices. [s. 221. (1) 5.]
(561)

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Jan 31, 2018(A1)

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Order / Ordre :

1) The licensee is to ensure that that medication carts are to be locked at all times when not in use and unattended.
2) The licensee is to develop and implement and audit to include checking of medication carts when left unattended to ensure they are locked.
3) The licensee is to provide education and training to all registered staff regarding the management of Narcotic and Controlled Drugs.

Grounds / Motifs :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

An unlocked medication cart was observed by the LTCH Inspector, with no staff present. Several residents were observed seated in the lounge. During an interview, RPN #133 reported the expectation was for the cart to be locked when unattended and confirmed the cart was unlocked and unattended. (585) [s. 129. (1) (a) (iii)] (585)

2. The non-compliance was issued as a compliance order (CO) due to a severity level of minimal harm or potential for actual harm (2), a scope of pattern(2) and a compliance history in the last three years of "one or more related noncompliance in the last three (full) years" (3) in keeping with s.299(1) of the Regulation.

The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

During observation of a morning medication pass, LTCH Inspector observed the medication cart and noticed that a number of sleeves containing controlled substances on a ring which were not stored in the separate narcotic bin which was double locked. The controlled substances were found outside of the narcotic bin in the bottom drawer of the medication cart. Registered staff #110 confirmed the medications should have been double locked and kept in the narcotic bin.
The home's policy titled "Management of Narcotic and Controlled Drugs", policy number RC-16-01-13, revised February 2017, indicated that all controlled substances were to be stored in a separate, double locked area within the locked medication cart.
The ADOC confirmed that all controlled substances were required to be stored in a locked narcotic bin in a locked medication cart.
The licensee failed to ensure that controlled substances were stored in a locked area within the locked medication cart. [s. 129. (1) (b)]

(561)

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

Jan 31, 2018(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 16 day of November 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : HEATHER PRESTON - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Service Area Office / Bureau régional de services : Hamilton