Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 18, 2018	2018_725522_0002	005117-18	Resident Quality Inspection

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Port Stanley
4551 East Road PORT STANLEY ON N5L 1J6

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

JULIE LAMPMAN (522), TERRI DALY (115)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 20, 21, 22, 23, 26, 27, 28, and 29, April 3, 4, 5, and 6, 2018.

The following intakes were completed within the Resident Quality Inspection:

Critical Incident System report #2669-000003-16/Log #012906-16 related to allegations of staff to resident abuse;
Critical Incident System report #2669-000002-17/Log #002157-17 related to allegations of staff to resident abuse;
Critical Incident System report #2669-000006-17/Log #009809-17 related to allegations of staff to resident abuse;
Critical Incident System report #2669-000008-17/Log #019149-17 related to allegations of staff to resident abuse;
Critical Incident System report #2669-000011-17/Log #027058-17 related to improper medication administration;
Critical Incident System report #2669-000014-17/Log #028627-17 related to a resident fall with injury;
Critical Incident System report #2669-000018-17/Log #029255-17 related to a resident fall with injury;

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Administrator, the Regional Director, the Program Manager, the Dietary Manager, the Resident Assessment Instrument (RAI) Coordinator, a Pharmacist, a Physiotherapy Aide, a Housekeeper, Registered Nurses, Registered Practical Nurses, Personal Support Workers, representatives from Family and Residents' Councils, family members and residents.

The inspectors also toured the home, observed resident care provision, resident and staff interactions, medication administration, medication storage areas, and the general maintenance and cleanliness of the home. Inspectors reviewed residents' clinical records, relevant meeting minutes, internal investigation notes, medication incident reports, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **19 WN(s)**
- **9 VPC(s)**
- **8 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff.

A) A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home on a specific date related to an incident of staff to resident abuse that occurred eight days earlier.

The CIS indicated a registered nurse (RN) witnessed an incident between a personal support worker (PSW) and a resident.

In an interview, the RN stated they had witnessed an incident of abuse between a PSW and an identified resident.

In an interview, the Program Manager (PM) confirmed that the home had completed an investigation into the allegation of abuse and acknowledged that the incident regarding the identified resident was considered abuse.

B) Another Critical Incident System (CIS) report was submitted to the MOHLTC by the home on a specific date, related to an incident of staff to resident abuse that occurred six days earlier.

The CIS indicated that a PSW witnessed an incident between another PSW and an identified resident.

In an interview, the PM confirmed that the home had completed an investigation into the allegation of abuse and acknowledged that the incident regarding the identified resident was considered abuse.

C) During review of a medication incident regarding an identified resident, the Resident Assessment Instrument (RAI) Coordinator stated that the registered nurse (RN) involved in the medication incident had been involved in an incident of neglect involving another identified resident.

In an interview, a RN confirmed they had brought forward concerns related to the identified RN's care of an identified resident.

In an interview, the PM confirmed that the home had completed an investigation into the allegation of neglect and acknowledged that the incident regarding the identified resident was considered neglect.

In an interview, the Acting Administrator acknowledged that the incidents involving the identified residents were considered abuse and neglect.

The licensee has failed to ensure residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 that promoted zero tolerance of abuse and neglect of residents was complied with.

A) On a specific date, the home called the Ministry of Health and Long-Term Care (MOHLTC) after hours pager to report an incident of staff to resident abuse. The report stated an investigation would be conducted and the staff involved would be interviewed.

A Critical Incident System (CIS) report was submitted to the MOHLTC by the home on a specific date, related to the incident of abuse involving the identified resident.

The home's policy Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences RC-02-01-03, last updated April 2017, stated, "During the investigation, the investigating manager/supervisor will maintain the security and integrity of the physical evidence at the site of incident, fully investigate the incident, and complete the documentation of all known details in keeping with steps outlined in the investigation toolkit." The policy also stated, "The Administrator or designate will oversee the

completion of all steps required by the policy and procedures, in order to manage the case to resolution. This includes: Ensuring that a copy of the documentation and all other evidence collected is stored within a secure area of the home."

In an interview, a Registered Nurse (RN) stated on a specific date they had submitted evidence regarding the incident of abuse to management.

During the inspection, the inspector requested the investigative notes into the allegations of abuse, including evidence, interviews with staff involved in the incident and the interview and follow-up with identified resident's family.

In an interview, the Program Manager (PM) stated that they were unable to find any documentation or evidence related to the investigation of abuse toward the identified resident and that there should have been documentation regarding the investigation into the incident.

B) During review of a medication incident regarding an identified resident, the Resident Assessment Instrument (RAI) Coordinator stated that the registered nurse (RN) involved in the medication incident had been involved in an incident of neglect involving another identified resident.

In an interview, a RN confirmed they had brought forward concerns related to the identified RN's care of an identified resident.

A review of the home's policy Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences RC-02-01-03, last updated April 2017, indicated, "Staff who have been found to have committed abuse or neglect and are registered members of a professional college or association, will be reported to their respective college or association."

A review of the home's investigative notes showed no documented evidence that the identified RN was reported to the College of Nurses of Ontario (CNO) for neglect.

In an interview, the PM stated the RN was not reported to the CNO.

In an interview, the Acting Administrator stated that the home should have reported the RN to the CNO.

The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knew of, or that was reported was immediately investigated:
(i) Abuse of a resident by anyone;
(ii) Neglect of a resident by the licensee or staff.

A) A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home on a specific date, related to a complaint from an identified resident's family member which alleged that the identified resident had been abused by a staff member.

A review of the home's investigative notes indicated on a specific date, the identified resident's family member reported the allegations of abuse to the Registered Practical

Nurse (RPN) on duty.

A review of the home's investigative notes indicated the RPN emailed the complaint detailing the concerns to the Administrator on the day the complaint was received. Review of email correspondence noted that the Administrator forwarded the complaint email to the Program Manager (PM) eleven days later and asked the PM to follow up on the complaint.

In an interview, the PM stated they did not receive the email from the Administrator until 11 days after the complaint was received, and initiated the investigation at that time.

In an interview, the Regional Director (RD) stated that when the delay in the complaint investigation came to their attention they addressed it with Administrator. The RD stated the investigation should have been initiated immediately.

B) A CIS report was submitted to the MOHLTC by the home on a specific date related to an incident of staff to resident abuse that occurred eight days earlier.

The CIS indicated a registered nurse (RN) witnessed an incident between a personal support worker (PSW) and a resident.

In an interview, the RN stated they had witnessed an incident of abuse between a PSW and an identified resident.

The RN stated that they had written a note to the previous Director of Care (DOC) regarding the incident and left it in their mail slot the day after the incident occurred. Review of the home's investigative notes included a hand written note to the DOC from the RN dated the day after the incident occurred.

In an interview, the PM stated that the RN and another PSW had submitted letters to the previous DOC on the specified date, regarding their concerns about the identified PSW's behaviour. The PM stated the previous Administrator and previous DOC began interviews regarding the alleged abuse seven days after the incident occurred.

In an interview, the Acting Administrator acknowledged that the incident of abuse should have been investigated immediately.

C) A CIS report was submitted to the MOHLTC by the home on a specific date, related to

an incident of staff to resident abuse that occurred six days earlier.

The CIS indicated that a PSW witnessed an incident between another PSW and an identified resident.

A review of the home's investigative notes indicated that meetings with the accused PSW and the staff on that shift did not occur until six days after the incident was reported to management.

In an interview, the PM stated they were not aware why the incident of abuse was not investigated immediately. The PM stated the previous DOC was only at the home three days per week and if the incident occurred when the DOC was not there, it was possible it was not investigated until the DOC was back in the office.

The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knew of, or that was reported was immediately investigated:
(i) Abuse of a resident by anyone;
(ii) Neglect of a resident by the licensee or staff. [s. 23. (1) (a)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

A) A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home on a specific date, related to a complaint from an identified resident's family member which alleged that the identified resident had been abused by a staff member.

A review of the home's investigative notes indicated on a specific date, the identified resident's family member reported the allegations of abuse to the Registered Practical Nurse (RPN) on duty.

A review of the home's investigative notes indicated the RPN emailed the complaint detailing the concerns to the Administrator on the day the complaint was received. Review of email correspondence noted that the Administrator forwarded the complaint email to the Program Manager (PM) eleven days later and asked the PM to follow up on the complaint.

In an interview, the PM stated they did not receive the email from the Administrator until

11 days after the complaint was received, and they had submitted the CIS report as soon as they found out about the complaint. The PM confirmed that the Administrator was on duty during the time the complaint was submitted up to and including when the email regarding the complaint was forwarded to the PM.

In an interview, the Regional Director (RD) stated that they did not think that it was normal practice at this home for registered staff to report to the MOHLTC. The RD stated that registered staff should have at least called the MOHLTC after hours line and then the Administrator should have submitted the CIS.

B) On a specific date, the home called the Ministry of Health and Long-Term Care (MOHLTC) after hours pager to report an incident of staff to resident abuse. The report stated an investigation would be conducted and the staff involved would be interviewed.

A Critical Incident System (CIS) report was submitted to the MOHLTC by the home on a specific date, four days after the incident of staff to resident abuse was reported to the MOHLTC after hours pager.

Review of the identified resident's electronic clinical record noted the resident's family member had reported concerns related to abuse to a registered nurse (RN) on a specific day, which was one day earlier than stated on the CIS.

In an interview, the PM stated that when the identified resident's family member reported their concerns to the RN on the specific date, the RN should she have reported this to management at that time.

In an interview, the Regional Director stated when the identified resident's family member had reported their concerns to the RN, the RN should have been in immediate contact with the Director of Care or Administrator and a CIS report should have been submitted at that time.

C) During review of a medication incident regarding an identified resident, the Resident Assessment Instrument (RAI) Coordinator stated that the registered nurse (RN) involved in the medication incident had been involved in an incident of neglect involving another identified resident.

In an interview, a RN confirmed they had brought forward concerns related to the identified RN's care of an identified resident.

In an interview, the Program Manager stated the Administrator would have been responsible to submit an incident report related to the incident of neglect. A review of CIS report submissions on Long-Term Care Homes.net with the PM noted that a CIS report had not been submitted to the MOHLTC by the home related to the incident of neglect involving the identified resident.

In an interview, the Regional Director acknowledged that the incident of neglect of the identified resident should have been reported to the MOHLTC immediately.

D) Another Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home on a specific date related to an incident of staff to resident abuse that occurred eight days earlier.

The CIS indicated a registered nurse (RN) witnessed an incident between a personal support worker (PSW) and a resident.

In an interview, the RN stated they had witnessed an incident of abuse between a PSW and an identified resident.

The RN stated that they had written a note to the previous Director of Care (DOC) regarding the incident and left it in their mail slot the day after the incident occurred. Review of the home's investigative notes included a hand written note to the DOC from the RN dated the day after the incident occurred.

In an interview, the PM stated that the RN and another PSW had submitted letters to the previous DOC on the specified date, regarding their concerns regarding the identified PSW's behaviour.

In an interview, the Acting Administrator stated that the incident should have been reported to the MOHLTC immediately.

E) Another Critical Incident System (CIS) report was submitted to the MOHLTC by the home on a specific date, related to an incident of staff to resident abuse that occurred six days earlier.

The CIS indicated that a PSW witnessed an incident between another PSW and an identified resident.

A review of the home's investigative notes noted that the incident was reported to management three days after the incident occurred.

In an interview, the PM stated they were not aware why the incident of abuse was not reported to the MOHLTC until six days after the incident occurred. The PM stated the Director of Care (DOC) was only at the home three days per week and if the incident occurred when the DOC was not there, it was possible it was not reported until the DOC was back in the office.

In an interview, the Regional Director stated that registered staff should have at least called the MOHLTC after hours line to report the abuse and management should have followed up with the CIS report.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home on a specific date, related to a complaint from an identified resident's family member which alleged that the identified resident had been abused by a staff member.

In an interview, when the inspector requested a record of complaints for 2017, the Acting Administrator (AA) stated that the home did not have a documented record of complaints for 2017. The AA stated they could only find an excel file of complaints logged for 2015.

The licensee has failed to ensure that a documented record was kept in the home that included,
(a) The nature of each verbal or written complaint;
(b) The date the complaint was received;
(c) The type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) The final resolution, if any;
(e) Every date on which any response was provided to the complainant and a description of the response; and
(f) Any response made in turn by the complainant. [s. 101. (2)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the Director of Nursing and Personal Care.

As part of the Resident Quality Inspection medication incidents were reviewed for the period of October to December 2017. In total there were eight medication incidents during this time period.

A) A review of a Medication Incident Report noted that an identified resident was administered the wrong dosage of medication. The Medication Incident Report indicated that the registered nurse calculated and gave the wrong dose of medication. There were no adverse effects to the resident.

B) A review of a Medication Incident Report noted that an identified resident was not administered their medication as ordered. The Medication Incident Report indicated that the medications were signed as administered by the registered nurse but they were still present in the medication strip. There were no adverse effects to the resident.

C) A review of a Medication Incident Report noted that an identified resident had been administered a medication that was to be on hold. The Medication Incident Report indicated when the doctor had been called due to a medical issue with the resident, the doctor reviewed the medication and determined that a specific medication was to be on hold. The resident continued to receive the medication due to a transcription error by the registered practical nurse.

All three medication incident reports did not include any documentation of the immediate actions taken to assess and maintain the residents’ health. There was no documentation to support that the Director of Care (DOC) was contacted regarding the medication incidents and there was no signature or date beside the section “DOC/Nurse Manager Comment.”

In an interview, the Regional Director acknowledged that the medication incident reports were incomplete and should have contained documentation related to the immediate

actions taken to assess and maintain the residents’ health and that the DOC should have been contacted.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and was reported to the Director of Nursing and Personal Care.

2. The licensee has failed to ensure that:
(a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed;
(b) corrective action was taken as necessary; and
(c) a written record was kept of everything required under clauses (a) and (b).

A) A review of a Medication Incident Report noted that an identified resident was administered the wrong dosage of medication. The Medication Incident Report indicated that the registered nurse calculated and gave the wrong dose of medication. There were no adverse effects to the resident.

The Medication Incident Report did not include any documentation related to the investigation of the medication incident and precipitating events.

A review of the action items noted that the RN was expected to attend a Mandatory Medication Safety meeting on a specific date.

In an interview, the Pharmacist stated that the Mandatory Medication Safety meeting was deferred. The Pharmacist stated they did not meet with the staff member to provided training on medication safety.

In an interview, the Regional Director (RD) stated that the RN should have received training on medication administration after the medication incident.

B) A review of a Medication Incident Report noted that an identified resident was not administered their medication as ordered. The Medication Incident Report indicated that the medications were signed as administered by the registered nurse but they were still present in the medication strip. There were no adverse effects to the resident.

The Medication Incident Report did not include any documentation related to the

investigation of the medication incident, action taken and precipitating events.

C) A review of a Medication Incident Report noted that an identified resident had been administered a medication that was to be on hold. The Medication Incident Report indicated when the doctor had been called due to a medical issue with the resident, the doctor reviewed the medication and determined that a specific medication was to be on hold. The resident continued to receive the medication due to a transcription error by the registered practical nurse.

The Medication Incident Report did not include any documentation related to the investigation of the medication incident, action taken with the RN and precipitating events.

In an interview, the Program Manager stated they had given the Administrator the meeting notes regarding the medication incident but stated they could not find any documentation the Administrator followed through with the RN.

In a phone interview, with the RN they stated that they had never received any follow up from the Adminstrator related to the medication incident.

In an interview, the RD indicated there should have been a discussion with the RN and it should have been documented.

In an interview, the Pharmacist stated that they reviewed trends with the previous Director of Care and then a summary was discussed with the team at Professional Advisory Committee (PAC) meetings.

A review of the PAC meeting minutes, with the Pharmacist noted the Clinical Consultant Pharmacist Quarterly Report. The report did not include a review and analysis of the medication incidents.

The report stated medication incidents were reviewed on a quarterly basis with the DOC and trends were identified. The report noted the following five incidents for October to December 2017:
October - Administration: Omission 1
November - Incorrect dose: 1
December - Administration: Omission 1,
Incorrect drug held:1

Order/Transcription: 1

The Pharmacist confirmed that the number of medication incidents that occurred for the period October to December 2017, did not match the total number of medication incident reports the home had which was eight. The Pharmacist indicated that online reporting was fairly new for the home and they tried to review the medication incidents they had against the medication incidents the home had to ensure they had all of the incidents.

In an interview, the RD acknowledged that the medication incidents were incomplete, corrective action should have been taken where necessary and the medication incidents should have been reviewed and analyzed. The RD stated that there should have been a record of all medication incidents and they should have been discussed at a PAC meeting.

The licensee has failed to ensure that:
(a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed;
(b) corrective action was taken as necessary; and
(c) a written record was kept of everything required under clauses (a) and (b). [s. 135.]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Findings/Faits saillants :

1. The licensee has failed to ensure that no staff performed their responsibilities before receiving training in the areas mentioned below: 11. Any other areas provided for in the regulations.

Ontario Regulation 79/10 s. 218 states, "For the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided: Safe and correct use of equipment, including therapeutic equipment, mechanical lifts,

assistive aids and positioning aids, that is relevant to the staff member's responsibilities."

In an interview, Inspector #522 and the Regional Director (RD) reviewed the training records of an identified personal support worker (PSW). The records showed that there was no documented evidence on file that the PSW had received training on the safe and correct use of mechanical lifts prior to the start of their duties or since they were hired.

Review of employee files of three recent hires note there were no training records on file related to the safe and correct use of mechanical lifts.

The RD stated that all new hires should receive training on how to use a mechanical lift, safety procedures and care plan requirements for residents related to the use of lifts. The RD stated there was a pre-transfer review package that staff would follow to use each lift and a competency checklist for new hires on the use of mechanical lifts that should be completed.

The licensee has failed to ensure that no staff performed their responsibilities before receiving in the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that was relevant to the staff member 's responsibilities.

2. The licensee has failed to ensure that no staff performed their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.

A) Review of an identified PSW's employee file noted that there was no documented evidence to support that the PSW had received any mandatory training prior to hire.

Review of employee files for five recent hires noted no training records on file or

documented evidence to support that the required mandatory training had been completed prior to the employees start date.

In an interview, the Regional Director (RD) stated that all new hires should complete the Extendicare Port Stanley Orientation Checklist-New Employees as well as the mandatory training prior to the start of their first shift. The RD confirmed there were no mandatory training records on file for the above employees.

B) A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home on a specific date, related to an incident of staff to resident abuse.

Review of the identified PSW's employee file noted the staff member did not complete training on abuse and neglect upon hire, nor did they complete annual mandatory training, after the incident of abuse of an identified resident.

In an interview, the Program Manager confirmed that the identified PSW did not complete training on zero tolerance of abuse and neglect prior to starting their position.

In an interview, the Regional Director and the Acting Administrator stated that the PSW should have received training prior to starting their position.

The licensee has failed to ensure that no staff performed their responsibilities before receiving training in the areas mentioned above.

3. The licensee has failed to ensure that all staff had received retraining annually relating to the following:
• The Residents' Bill of Rights;
• The home's policy to promote zero tolerance of abuse and neglect of residents;
• The duty to make mandatory reports under section 24;
• The whistle-blowing protections.

A review of the home's mandatory training records for 2017 indicated that 51 of 84 (60.7%) of staff had not completed required mandatory training in the following:
The Residents' Bill of Rights;
The home's policy to promote zero tolerance of abuse and neglect of residents;
The duty to make mandatory reports under section 24; and
The whistle-blowing protections.

In an interview, the Acting Administrator stated that all staff should have received training in the above areas in 2017.

The licensee has failed to ensure that all staff had received retraining annually relating to the above areas.

4. The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.

Ontario Regulation s. 221. (2) 2 states, "The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs."

A Critical Incident System (CIS) report was submitted to the MOHLTC by the home on a specific date, related to the incident of staff to resident abuse.

A review of the CIS indicated that the Personal Support Worker (PSW) involved was to have education on the home's zero tolerance of abuse policy.

In an interview, the Program Manager (PM) stated the PSW accused of alleged abuse was to have retraining on the zero tolerance of abuse policy. A review of the PSW's training record from iTacit with the PM indicated that the PSW did not complete any retraining on zero tolerance of abuse and neglect after the incident of alleged abuse.

In an interview, the Acting Administrator stated that the PSW should have received training on abuse and neglect.

The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in abuse recognition and prevention.

5. The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas

set out in the following paragraphs, at times or at intervals provided for in the regulations:
6. Any other areas provided for in the regulations.

Ontario Regulation s. 221 (1) states, "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: Falls prevention and management."

Ontario Regulation s. 221. (2) states, "The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act."

A review of the home's policy Mandatory Education for Staff, Students and Volunteers RC-01-01-02, Appendix 1, last updated January 2018, indicated that registered staff were to receive annual mandatory training in falls prevention and assessment.

A review of direct care staff training records for 2017 indicated that 8 of 17 (40%) of registered staff had not completed required training in falls prevention and management in 2017.

In an interview, the Acting Administrator stated that all registered staff should have received annual training in falls prevention and management.

The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in falls prevention and management. [s. 76.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 216 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, at least annually, the training and orientation program was evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A review of the home's mandatory training records for 2017 indicated that 51 of 84 (60.7%) of staff had not completed required mandatory training in the following:
The Residents' Bill of Rights;
The home's policy to promote zero tolerance of abuse and neglect of residents;
The duty to make mandatory reports under section 24;
The whistle-blowing protections.

In an interview, the Program Manager (PM) provided information related to the evaluation of the training and orientation program. Upon review of the evaluation there was no date on the evaluation and no signatures at the bottom of the evaluation.

The PM stated although there was some information in the evaluation, there was no documented evidence to support that the evaluation was for 2017, as the document was not signed and there was no date to indicate when the evaluation was actually completed.

In an interview, the Acting Administrator and the Regional Director stated that since there was no date on the evaluation and it was not signed then it was considered not complete for 2017.

The licensee has failed to ensure that, at least annually, the training and orientation program was evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. [s. 216. (2)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care by the home on a specific date, related to the fall of an identified resident.

A review of the CIS report indicated that two personal support workers (PSWs) were transferring the identified resident when the resident fell.

In an interview, a Registered Nurse (RN) stated they had assessed the identified resident after their fall. The RN stated that staff had not transferred the resident appropriately.

In an interview, the Resident Assessment Instrument (RAI) Coordinator stated that the PSWs had not transferred the resident safely.

In an interview, the Regional Director (RD) stated that staff had not transferred the resident safely.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care by the home on a specific date, related to an incident of staff to resident abuse that occurred on a specific date.

The CIS indicated that an identified resident's family member had complained that the identified resident had altered skin integrity.

Review of the identified resident's electronic clinical record noted no documented evidence to support that the resident had received a skin assessment.

In an interview, a Registered Nurse (RN) stated they had looked at the identified resident's skin and made a note in the resident's progress notes but they had not completed a skin assessment. A review of the identified resident's electronic clinical record with the RN indicated the absence of a skin assessment for the identified resident related to the altered skin integrity.

In an interview, the Acting Administrator stated the identified resident should have had a skin assessment completed when their family member reported the altered skin integrity.

The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home on a specific date, related to an incident of staff to resident abuse.

The CIS indicated the resident's substitute decision-maker (SDM) had not been notified about the incident and that the family would be contacted about the situation.

A review of the home's investigative notes and resident's electronic progress notes noted no documented evidence to support that the resident's SDM had been contacted about the incident of abuse.

In an interview, the Program Manager reviewed the notes and acknowledged the family had not been notified by the previous Director of Care.

In an interview, the Acting Administrator acknowledged that the identified resident's SDM should have been notified of the incident of abuse.

B) During review of a medication incident regarding an identified resident, the Resident Assessment Instrument (RAI) Coordinator stated that the registered nurse (RN) involved in the medication incident had been involved in an incident of neglect involving another identified resident.

In an interview, a RN confirmed they had brought forward concerns related to the identified RN's care of an identified resident.

A review of the home's investigative notes and resident's electronic progress notes noted no documented evidence that the resident's SDM had been contacted about the incident of abuse.

In an interview, the Regional Director and the Acting Administrator stated the identified resident's SDM should have been notified of the incident of neglect.

The licensee has failed to ensure that the resident's substitute decision-maker and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident, or that caused distress to the resident that could potentially be detrimental to the resident' s health or well-being. [s. 97. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's substitute decision-maker and any other person specified by the resident are immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident, or that causes distress to the resident that could potentially be detrimental to the resident' s health or well-being, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence.

A) On a specific date, the home called the Ministry of Health and Long-Term Care (MOHLTC) after hours pager to report an incident of staff to resident abuse.

A Critical Incident System (CIS) report was submitted to the MOHLTC by the home on a specific date, related to the incident of abuse involving the identified resident.

Review of the CIS showed no documentation that the police had been notified of the alleged incident of abuse.

B) A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home on a specific date related to an incident of staff to resident abuse.

The CIS indicated a registered nurse (RN) witnessed an incident between a personal support worker (PSW) and a resident.

In an interview, the RN stated they had witnessed an incident of abuse between a PSW and an identified resident.

In an interview, the Program Manager stated the home had not notified the police regarding the incidents of abuse involving both identified residents.

In an interview, the Acting Administrator stated that they understood that the police should have been notified of the incidents of abuse.

The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence. [s. 98.]

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 appropriate police force is immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents.

During the review of the incidents of alleged abuse and neglect, Inspector #522 requested the home's annual evaluation of their policy to promote zero tolerance of abuse and neglect of residents.

In an interview, the Acting Administrator (AA) stated that there was no annual evaluation for 2017 completed of the home's policy to promote zero tolerance of abuse and neglect of residents. The AA stated an evaluation should have been completed.

The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents. [s. 99. (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 at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the report to the Director included the following description of the individuals involved in the incident:
(i) names of all residents involved in the incident,
(ii) names of any staff members or other persons who were present at or discovered the incident.

A) A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home on a specific date, related to a complaint from an identified resident's family member which alleged that the identified resident had been abused by a staff member.

Review of the CIS did not include the name of the Personal Support Worker (PSW) who was reported to have allegedly abused the resident.

B) Another CIS report was submitted to the MOHLTC by the home on a specific date, related to an incident of staff to resident abuse.

The CIS did not identify the name of the resident or PSW involved in the incident.

C) Another CIS report was submitted to the MOHLTC by the home on a specific date, related to an incident of staff to resident abuse.

The CIS did not identify the name of the PSW involved in the incident.

In an interview, the Program Manager informed the inspector of the name of the resident and PSWs involved in the incidents.

In an interview, the Acting Administrator stated the name of the resident and PSWs involved should have been included on the CIS reports.

The licensee failed to ensure that the report to the Director included the following description of the individuals involved in the incident:
(i) names of all residents involved in the incident,
(ii) names of any staff members or other persons who were present at or discovered the incident. [s. 104. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the report to the Director includes the following description of the individuals involved in the incident: names of all residents involved in the incident, and names of any staff members or other persons who were present at or discovered the incident, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

As part of the Resident Quality Inspection medication incidents were reviewed for the period of October to December 2017. In total there were eight medication incidents during this time period.

A) A review of a Medication Incident Report noted that an identified resident was administered the wrong dosage of medication. The Medication Incident Report indicated that the registered nurse calculated and gave the wrong dose of medication. There were no adverse effects to the resident.

B) A review of a Medication Incident Report noted that an identified resident was not administered their medication as ordered. The Medication Incident Report indicated that the medications were signed as administered by the registered nurse but they were still present in the medication strip. There were no adverse effects to the resident.

C) A review of a Medication Incident Report noted that an identified resident had been administered a medication that was to be on hold. The Medication Incident Report indicated when the doctor had been called due to a medical issue with the resident, the doctor reviewed the medication and determined that a specific medication was to be on hold. The resident continued to receive the medication due to a transcription error by the registered practical nurse.

In an interview, the Regional Director reviewed the medication incidents and indicated that the medications were not administered as ordered by the physician.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate actions were taken in response to any medication incident involving a resident.

As part of the Resident Quality Inspection medication incidents were reviewed for the period of October to December 2017.

A review of a Medication Incident Report noted that an identified resident was not administered their medication as ordered. The Medication Incident Report indicated that the medications were signed as administered by the registered nurse (RN) but they were still present in the medication strip. There were no adverse effects to the resident.

In an interview, a RN stated when they came on their shift on a specific date, they noticed the identified resident’s medications were signed as given but the medications were still in the medication strip. The RN stated one of the medications the identified resident was on was for an identified medical condition.

The identified resident’s electronic chart was reviewed with the RN and there was no documentation to support that the resident’s condition had been monitored after the resident missed their dose of medication. The RN stated the identified resident's condition should have been monitored.

In an interview, the RN identified in the medication incident report, stated the identified resident was sleeping and the RN neglected to give the resident their meds. The RN stated they set the medication aside to give to the resident, signed it as given and then forgot to give it to the resident. The RN stated they did not know why the resident was on the identified medication.

The licensee has failed to ensure that appropriate actions were taken in response to any medication incident involving a resident. [s. 134. (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 appropriate actions are taken in response to any medication incident involving a resident, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 215. Criminal reference check

Specifically failed to comply with the following:

s. 215. (2) The criminal reference check must be,
(a) conducted by a police force; and O. Reg. 79/10, s. 215 (2).
(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee. O. Reg. 79/10, s. 215 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a criminal reference check was conducted within six months before the staff member was hired.

A review of pre-screening for five new hires noted that a personal support worker with a specific hire date, had a police check on file that was dated 13 months prior to their date of hire.

In an interview, the Regional Director confirmed that the police check should have been completed within six months of the date of hire.

The licensee has failed to ensure that a criminal reference check was conducted within six months before the staff member was hired. [s. 215. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a criminal reference check is conducted within six months before the staff member is hired, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responded in writing within 10 days of receiving Resident's Council advice related to concerns or recommendations.

In an interview, the Residents' Council representative, stated that they did not know if concerns or recommendations were responded to in writing within 10 days, that they believed the responses were reviewed at the next monthly meeting. Upon review of meeting minutes from a specific date, regarding a concern that was shared related to a specific resident, the representative immediately recognized that this was their concern but did not feel that it was followed up or addressed.

Review of the Residents' Council Meeting minutes from three specific meetings noted four separate concerns that were brought forward from residents.

In an interview, the Program Manager said that some of these issues would have been corrected immediately and others would have been referred to specific managers for follow up, but that there was no written documentation to support that any of these issues were responded to in writing within 10 days.

A review of the home's policy Residents' Council Policy Reference # OPER 02-02-08 version June 2014, stated under Policy Statement "The Administrator will respond within 10 days to all concerns/questions/complaints raised by the Residents' Council. (or as required by standards or legislation within the Province the home is located).

In an interview, the Regional Director said it was the expectation that the home responded in writing to concerns or recommendations from Residents' Council within 10 days.

The licensee has failed to ensure that the licensee responded in writing within 10 days of receiving Resident's Council advice related to concerns or recommendations. [s. 57. (2)]

WN #19: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that when they were required to inform the Director of an incident under subsection (1), (3) or (3.1) they shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the outcome or current status of the individuals who were involved in the incident.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date. During a review of the report, it was noted that an identified resident had sustained a fall.

The report showed an amendment was requested by the MOHLTC, requesting the outcome and the status of resident.

In an interview, the Program Manager stated the amendment to the CIS was not completed as requested by the Director.

The licensee has failed to ensure that when they were required to inform the Director of an incident under subsection (1), (3) or (3.1) they shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the outcome or current status of the individuals who were involved in the incident. [s. 107. (4) 3. v.]

Issued on this 28th day of September, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE LAMPMAN (522), TERRI DALY (115)
Inspection No. / No de l'inspection :	2018_725522_0002
Log No. / No de registre :	005117-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 18, 2018
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Port Stanley 4551 East Road, PORT STANLEY, ON, N5L-1J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lynsey McIntyre

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 :

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

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA.

Specifically the licensee shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. 1. The licensee has failed to ensure residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff.

A) A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home on a specific date related to an incident of staff to resident abuse that occurred eight days earlier.

The CIS indicated a registered nurse (RN) witnessed an incident between a personal support worker (PSW) and a resident.

In an interview, the RN stated they had witnessed an incident of abuse between a PSW and an identified resident.

In an interview, the Program Manager (PM) confirmed that the home had completed an investigation into the allegation of abuse and acknowledged that the incident regarding the identified resident was considered abuse.

B) Another Critical Incident System (CIS) report was submitted to the MOHLTC by the home on a specific date, related to an incident of staff to resident abuse that occurred six days earlier.

The CIS indicated that a PSW witnessed an incident between another PSW and an identified resident.

In an interview, the PM confirmed that the home had completed an investigation into the allegation of abuse and acknowledged that the incident regarding the identified resident was considered abuse.

C) During review of a medication incident regarding an identified resident, the Resident Assessment Instrument (RAI) Coordinator stated that the registered nurse (RN) involved in the medication incident had been involved in an incident of neglect involving another identified resident.

In an interview, a RN confirmed they had brought forward concerns related to the identified RN's care of an identified resident.

In an interview, the PM confirmed that the home had completed an investigation into the allegation of neglect and acknowledged that the incident regarding the identified resident was considered neglect.

In an interview, the Acting Administrator acknowledged that the incidents involving the identified residents were considered abuse and neglect.

The licensee has failed to ensure residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The severity of this issue was determined to be a level 3 as there was actual harm/risk to the resident. The scope of the issue was a level 2 as it related to 3 out of 5 incidents reviewed. The home had a level 2 history of unrelated noncompliance. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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).

Order / Ordre :

The licensee must be compliant with s. 20 (1) of the LTCHA.

Specifically the licensee shall ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

Grounds / Motifs :

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

A) On a specific date, the home called the Ministry of Health and Long-Term Care (MOHLTC) after hours pager to report an incident of staff to resident abuse. The report stated an investigation would be conducted and the staff involved would be interviewed.

A Critical Incident System (CIS) report was submitted to the MOHLTC by the home on a specific date, related to the incident of abuse involving the identified resident.

The home's policy Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences RC-02-01-03, last updated April 2017, stated, "During the investigation, the investigating manager/supervisor will maintain the security and integrity of the physical evidence at the site of incident, fully investigate the incident, and complete the documentation of all known details in keeping with steps outlined in the investigation toolkit." The policy also stated, "The Administrator or designate will oversee the completion of all steps required by

the policy and procedures, in order to manage the case to resolution. This includes: Ensuring that a copy of the documentation and all other evidence collected is stored within a secure area of the home."

In an interview, a Registered Nurse (RN) stated on a specific date they had submitted evidence regarding the incident of abuse to management.

During the inspection, the inspector requested the investigative notes into the allegations of abuse, including evidence, interviews with staff involved in the incident and the interview and follow-up with identified resident's family.

In an interview, the Program Manager (PM) stated that they were unable to find any documentation or evidence related to the investigation of abuse toward the identified resident and that there should have been documentation regarding the investigation into the incident.

B) During review of a medication incident regarding an identified resident, the Resident Assessment Instrument (RAI) Coordinator stated that the registered nurse (RN) involved in the medication incident had been involved in an incident of neglect involving another identified resident.

In an interview, a RN confirmed they had brought forward concerns related to the identified RN's care of an identified resident.

A review of the home's policy Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences RC-02-01-03, last updated April 2017, indicated, "Staff who have been found to have committed abuse or neglect and are registered members of a professional college or association, will be reported to their respective college or association."

A review of the home's investigative notes showed no documented evidence that the identified RN was reported to the College of Nurses of Ontario (CNO) for neglect.

In an interview, the PM stated the RN was not reported to the CNO.

In an interview, the Acting Administrator stated that the home should have reported the RN to the CNO.

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

The severity of this issue was determined to be a level 3 as there was actual harm/risk to the resident. The scope of the issue was a level 2 as it related to 2 out of 5 incidents reviewed. The home had a level 2 history of unrelated noncompliance. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2018

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 23 (1) (a) of the LTCHA.

Specifically the licensee shall ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:
(i) Abuse of a resident by anyone;
(ii) Neglect of a resident by the licensee or staff.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knew of, or that was reported was immediately investigated:
(i) Abuse of a resident by anyone;
(ii) Neglect of a resident by the licensee or staff.

A) A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home on a specific date, related to a complaint from an identified resident's family member which alleged that the

identified resident had been abused by a staff member.

A review of the home's investigative notes indicated on a specific date, the identified resident's family member reported the allegations of abuse to the Registered Practical Nurse (RPN) on duty.

A review of the home's investigative notes indicated the RPN emailed the complaint detailing the concerns to the Administrator on the day the complaint was received. Review of email correspondence noted that the Administrator forwarded the complaint email to the Program Manager (PM) eleven days later and asked the PM to follow up on the complaint.

In an interview, the PM stated they did not receive the email from the Administrator until 11 days after the complaint was received, and initiated the investigation at that time.

In an interview, the Regional Director (RD) stated that when the delay in the complaint investigation came to their attention they addressed it with Administrator. The RD stated the investigation should have been initiated immediately.

B) A CIS report was submitted to the MOHLTC by the home on a specific date related to an incident of staff to resident abuse that occurred eight days earlier.

The CIS indicated a registered nurse (RN) witnessed an incident between a personal support worker (PSW) and a resident.

In an interview, the RN stated they had witnessed an incident of abuse between a PSW and an identified resident.

The RN stated that they had written a note to the previous Director of Care (DOC) regarding the incident and left it in their mail slot the day after the incident occurred. Review of the home's investigative notes included a hand written note to the DOC from the RN dated the day after the incident occurred.

In an interview, the PM stated that the RN and another PSW had submitted letters to the previous DOC on the specified date, regarding their concerns about the identified PSW's behaviour. The PM stated the previous Administrator and previous DOC began interviews regarding the alleged abuse seven days after

the incident occurred.

In an interview, the Acting Administrator acknowledged that the incident of abuse should have been investigated immediately.

C) A CIS report was submitted to the MOHLTC by the home on a specific date, related to an incident of staff to resident abuse that occurred six days earlier.

The CIS indicated that a PSW witnessed an incident between another PSW and an identified resident.

A review of the home's investigative notes indicated that meetings with the accused PSW and the staff on that shift did not occur until six days after the incident was reported to management.

In an interview, the PM stated they were not aware why the incident of abuse was not investigated immediately. The PM stated the previous DOC was only at the home three days per week and if the incident occurred when the DOC was not there, it was possible it was not investigated until the DOC was back in the office.

The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knew of, or that was reported was immediately investigated:
(i) Abuse of a resident by anyone;
(ii) Neglect of a resident by the licensee or staff.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the resident. The scope of the issue was a level 2 as it related to 3 out of 5 incidents reviewed. The home had a level 2 history of unrelated noncompliance. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2018

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 24 (1) of the LTCHA.

Specifically the licensee shall ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

A) A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home on a specific date, related to a complaint from an identified resident's family member which alleged that the identified resident had been abused by a staff member.

A review of the home's investigative notes indicated on a specific date, the identified resident's family member reported the allegations of abuse to the Registered Practical Nurse (RPN) on duty.

A review of the home's investigative notes indicated the RPN emailed the complaint detailing the concerns to the Administrator on the day the complaint was received. Review of email correspondence noted that the Administrator forwarded the complaint email to the Program Manager (PM) eleven days later and asked the PM to follow up on the complaint.

In an interview, the PM stated they did not receive the email from the Administrator until 11 days after the complaint was received, and they had submitted the CIS report as soon as they found out about the complaint. The PM confirmed that the Administrator was on duty during the time the complaint was submitted up to and including when the email regarding the complaint was forwarded to the PM.

In an interview, the Regional Director (RD) stated that they did not think that it was normal practice at this home for registered staff to report to the MOHLTC. The RD stated that registered staff should have at least called the MOHLTC after hours line and then the Administrator should have submitted the CIS.

B) On a specific date, the home called the Ministry of Health and Long-Term Care (MOHLTC) after hours pager to report an incident of staff to resident abuse. The report stated an investigation would be conducted and the staff involved would be interviewed.

A Critical Incident System (CIS) report was submitted to the MOHLTC by the home on a specific date, four days after the incident of staff to resident abuse was reported to the MOHLTC after hours pager.

Review of the identified resident's electronic clinical record noted the resident's family member had reported concerns related to abuse to a registered nurse (RN) on a specific day, which was one day earlier than stated on the CIS.

In an interview, the PM stated that when the identified resident's family member reported their concerns to the RN on the specific date, the RN should she have reported this to management at that time.

In an interview, the Regional Director stated when the identified resident's family member had reported their concerns to the RN, the RN should have been in immediate contact with the Director of Care or Administrator and a CIS report should have been submitted at that time.

C) During review of a medication incident regarding an identified resident, the Resident Assessment Instrument (RAI) Coordinator stated that the registered nurse (RN) involved in the medication incident had been involved in an incident of neglect involving another identified resident.

In an interview, a RN confirmed they had brought forward concerns related to the identified RN's care of an identified resident.

In an interview, the Program Manager stated the Administrator would have been responsible to submit an incident report related to the incident of neglect. A review of CIS report submissions on Long-Term Care Homes.net with the PM noted that a CIS report had not been submitted to the MOHLTC by the home related to the incident of neglect involving the identified resident.

In an interview, the Regional Director acknowledged that the incident of neglect of the identified resident should have been reported to the MOHLTC immediately.

D) Another Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home on a specific date related to an incident of staff to resident abuse that occurred eight days earlier.

The CIS indicated a registered nurse (RN) witnessed an incident between a personal support worker (PSW) and a resident.

In an interview, the RN stated they had witnessed an incident of abuse between a PSW and an identified resident.

The RN stated that they had written a note to the previous Director of Care (DOC) regarding the incident and left it in their mail slot the day after the incident occurred. Review of the home's investigative notes included a hand written note to the DOC from the RN dated the day after the incident occurred.

In an interview, the PM stated that the RN and another PSW had submitted

letters to the previous DOC on the specified date, regarding their concerns regarding the identified PSW's behaviour.

In an interview, the Acting Administrator stated that the incident should have been reported to the MOHLTC immediately.

E) Another Critical Incident System (CIS) report was submitted to the MOHLTC by the home on a specific date, related to an incident of staff to resident abuse that occurred six days earlier.

The CIS indicated that a PSW witnessed an incident between another PSW and an identified resident.

A review of the home's investigative notes noted that the incident was reported to management three days after the incident occurred.

In an interview, the PM stated they were not aware why the incident of abuse was not reported to the MOHLTC until six days after the incident occurred. The PM stated the Director of Care (DOC) was only at the home three days per week and if the incident occurred when the DOC was not there, it was possible it was not reported until the DOC was back in the office.

In an interview, the Regional Director stated that registered staff should have at least called the MOHLTC after hours line to report the abuse and management should have followed up with the CIS report.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the resident. The scope of the issue was a level 3 as it related to 5 out of 5 incidents reviewed. The home had a level 3 history of noncompliance of with this section of the LTCHA that included a Voluntary Plan of Correction (VPC) issued November 7, 2016 (2016_277538_0026). (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2018

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 101 (2) of O. Reg. 79/10.

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

Grounds / Motifs :

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

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home on a specific date, related to a complaint from an identified resident's family member which alleged that the identified resident had been abused by a staff member.

In an interview, when the inspector requested a record of complaints for 2017, the Acting Administrator (AA) stated that the home did not have a documented record of complaints for 2017. The AA stated they could only find an excel file of complaints logged for 2015.

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

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the resident. The scope of the issue was a level 3 as the home did not have a record of any complaints since 2015. The home had a level 2 history of unrelated noncompliance. (522)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2018

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Order / Ordre :

The licensee must be compliant with s. 135 of O. Reg. 79/10.

Specifically the licensee shall ensure that every medication incident involving a resident and every adverse drug reaction:

a) Is documented, together with a record of the immediate actions taken to assess and maintain the resident's health;
b) Is reported to the Director of Nursing and Personal Care;
c) Is reviewed and analyzed;
d) Corrective action is taken as necessary; and
e) A written record is kept of everything.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the Director of Nursing and Personal Care.

As part of the Resident Quality Inspection medication incidents were reviewed for the period of October to December 2017. In total there were eight medication incidents during this time period.

A) A review of a Medication Incident Report noted that an identified resident was administered the wrong dosage of medication. The Medication Incident Report indicated that the registered nurse calculated and gave the wrong dose of medication. There were no adverse effects to the resident.

B) A review of a Medication Incident Report noted that an identified resident was not administered their medication as ordered. The Medication Incident Report

indicated that the medications were signed as administered by the registered nurse but they were still present in the medication strip. There were no adverse effects to the resident.

C) A review of a Medication Incident Report noted that an identified resident had been administered a medication that was to be on hold. The Medication Incident Report indicated when the doctor had been called due to a medical issue with the resident, the doctor reviewed the medication and determined that a specific medication was to be on hold. The resident continued to receive the medication due to a transcription error by the registered practical nurse.

All three medication incident reports did not include any documentation of the immediate actions taken to assess and maintain the residents' health. There was no documentation to support that the Director of Care (DOC) was contacted regarding the medication incidents and there was no signature or date beside the section "DOC/Nurse Manager Comment."

In an interview, the Regional Director acknowledged that the medication incident reports were incomplete and should have contained documentation related to the immediate actions taken to assess and maintain the residents' health and that the DOC should have been contacted.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and was reported to the Director of Nursing and Personal Care.

2. The licensee has failed to ensure that:
(a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed;
(b) corrective action was taken as necessary; and
(c) a written record was kept of everything required under clauses (a) and (b).

A) A review of a Medication Incident Report noted that an identified resident was administered the wrong dosage of medication. The Medication Incident Report indicated that the registered nurse calculated and gave the wrong dose of medication. There were no adverse effects to the resident.

The Medication Incident Report did not include any documentation related to the

investigation of the medication incident and precipitating events.

A review of the action items noted that the RN was expected to attend a Mandatory Medication Safety meeting on a specific date.

In an interview, the Pharmacist stated that the Mandatory Medication Safety meeting was deferred. The Pharmacist stated they did not meet with the staff member to provided training on medication safety.

In an interview, the Regional Director (RD) stated that the RN should have received training on medication administration after the medication incident.

B) A review of a Medication Incident Report noted that an identified resident was not administered their medication as ordered. The Medication Incident Report indicated that the medications were signed as administered by the registered nurse but they were still present in the medication strip. There were no adverse effects to the resident.

The Medication Incident Report did not include any documentation related to the investigation of the medication incident, action taken and precipitating events.

C) A review of a Medication Incident Report noted that an identified resident had been administered a medication that was to be on hold. The Medication Incident Report indicated when the doctor had been called due to a medical issue with the resident, the doctor reviewed the medication and determined that a specific medication was to be on hold. The resident continued to receive the medication due to a transcription error by the registered practical nurse.

The Medication Incident Report did not include any documentation related to the investigation of the medication incident, action taken with the RN and precipitating events.

In an interview, the Program Manager stated they had given the Administrator the meeting notes regarding the medication incident but stated they could not find any documentation the Administrator followed through with the RN.

In a phone interview, with the RN they stated that they had never received any follow up from the Adminstrator related to the medication incident.

In an interview, the RD indicated there should have been a discussion with the RN and it should have been documented.

In an interview, the Pharmacist stated that they reviewed trends with the previous Director of Care and then a summary was discussed with the team at Professional Advisory Committee (PAC) meetings.

A review of the PAC meeting minutes, with the Pharmacist noted the Clinical Consultant Pharmacist Quarterly Report. The report did not include a review and analysis of the medication incidents.

The report stated medication incidents were reviewed on a quarterly basis with the DOC and trends were identified. The report noted the following five incidents for October to December 2017:
October - Administration: Omission 1
November - Incorrect dose: 1
December - Administration: Omission 1,
Incorrect drug held:1
Order/Transcription: 1

The Pharmacist confirmed that the number of medication incidents that occurred for the period October to December 2017, did not match the total number of medication incident reports the home had which was eight. The Pharmacist indicated that online reporting was fairly new for the home and they tried to review the medication incidents they had against the medication incidents the home had to ensure they had all of the incidents.

In an interview, the RD acknowledged that the medication incidents were incomplete, corrective action should have been taken where necessary and the medication incidents should have been reviewed and analyzed. The RD stated that there should have been a record of all medication incidents and they should have been discussed at a PAC meeting.

The licensee has failed to ensure that:
(a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed;
(b) corrective action was taken as necessary; and
(c) a written record was kept of everything required under clauses (a) and (b).

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the resident. The scope of the issue was a level 3 as it involved 3 out of 3 medication incidents reviewed. The home had a level 3 history of noncompliance with this section of O. Reg 79/10 that included a voluntary plan of correction (VPC) issued November 17, 2017 (2017_508137_0025). (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2018

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Order / Ordre :

The licensee must be compliant with s. 76 of the LTCHA.

Specifically the licensee shall ensure the following:

a) No staff performs their responsibilities before receiving training in the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities;

b) No staff performs their responsibilities before receiving training in the areas mentioned below:
i. The Residents' Bill of Rights.
ii. The long-term care home's mission statement.
iii. The long-term care home's policy to promote zero tolerance of abuse neglect of residents.
iv. The duty under section 24 to make mandatory reports.
v. The protections afforded by section 26.
vi. The long-term care home's policy to minimize the restraining of residents.
vii. Fire prevention and safety.
viii. Emergency and evacuation procedures.
ix. Infection prevention and control.

c) All staff receive training annually relating to the following:
i. The Residents' Bill of Rights;
ii. The home's policy to promote zero tolerance of abuse and neglect of residents;
iii. The duty to make mandatory reports under section 24;
iv. The whistle-blowing protections.

d) All staff who provide direct care to residents receive annual training in abuse recognition and prevention.

e) All staff who provide direct care to residents receive annual training in falls prevention and management.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that no staff performed their responsibilities before receiving training in the areas mentioned below: 11. Any

other areas provided for in the regulations.

Ontario Regulation 79/10 s. 218 states, "For the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided: Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities."

In an interview, Inspector #522 and the Regional Director (RD) reviewed the training records of an identified personal support worker (PSW). The records showed that there was no documented evidence on file that the PSW had received training on the safe and correct use of mechanical lifts prior to the start of their duties or since they were hired.

Review of employee files of three recent hires note there were no training records on file related to the safe and correct use of mechanical lifts.

The RD stated that all new hires should receive training on how to use a mechanical lift, safety procedures and care plan requirements for residents related to the use of lifts. The RD stated there was a pre-transfer review package that staff would follow to use each lift and a competency checklist for new hires on the use of mechanical lifts that should be completed.

The licensee has failed to ensure that no staff performed their responsibilities before receiving in the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that was relevant to the staff member's responsibilities.

2. The licensee has failed to ensure that no staff performed their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.

9. Infection prevention and control.

A) Review of an identified PSW's employee file noted that there was no documented evidence to support that the PSW had received any mandatory training prior to hire.

Review of employee files for five recent hires noted no training records on file or documented evidence to support that the required mandatory training had been completed prior to the employees start date.

In an interview, the Regional Director (RD) stated that all new hires should complete the Extendicare Port Stanley Orientation Checklist-New Employees as well as the mandatory training prior to the start of their first shift. The RD confirmed there were no mandatory training records on file for the above employees.

B) A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home on a specific date, related to an incident of staff to resident abuse.

Review of the identified PSW's employee file noted the staff member did not complete training on abuse and neglect upon hire, nor did they complete annual mandatory training, after the incident of abuse of an identified resident.

In an interview, the Program Manager confirmed that the identified PSW did not complete training on zero tolerance of abuse and neglect prior to starting their position.

In an interview, the Regional Director and the Acting Administrator stated that the PSW should have received training prior to starting their position.

The licensee has failed to ensure that no staff performed their responsibilities before receiving training in the areas mentioned above.

3. The licensee has failed to ensure that all staff had received retraining annually relating to the following:
• The Residents' Bill of Rights;
• The home's policy to promote zero tolerance of abuse and neglect of residents;
• The duty to make mandatory reports under section 24;

• The whistle-blowing protections.

A review of the home's mandatory training records for 2017 indicated that 51 of 84 (60.7%) of staff had not completed required mandatory training in the following:
The Residents' Bill of Rights;
The home's policy to promote zero tolerance of abuse and neglect of residents;
The duty to make mandatory reports under section 24; and
The whistle-blowing protections.

In an interview, the Acting Administrator stated that all staff should have received training in the above areas in 2017.

The licensee has failed to ensure that all staff had received retraining annually relating to the above areas.

4. The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.

Ontario Regulation s. 221. (2) 2 states, "The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs."

A Critical Incident System (CIS) report was submitted to the MOHLTC by the home on a specific date, related to the incident of staff to resident abuse.

A review of the CIS indicated that the Personal Support Worker (PSW) involved was to have education on the home's zero tolerance of abuse policy.

In an interview, the Program Manager (PM) stated the PSW accused of alleged abuse was to have retraining on the zero tolerance of abuse policy. A review of the PSW's training record from iTacit with the PM indicated that the PSW did not complete any retraining on zero tolerance of abuse and neglect after the incident

of alleged abuse.

In an interview, the Acting Administrator stated that the PSW should have received training on abuse and neglect.

The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in abuse recognition and prevention.

5. The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
6. Any other areas provided for in the regulations.

Ontario Regulation s. 221 (1) states, "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: Falls prevention and management."

Ontario Regulation s. 221. (2) states, "The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act."

A review of the home's policy Mandatory Education for Staff, Students and Volunteers RC-01-01-02, Appendix 1, last updated January 2018, indicated that registered staff were to receive annual mandatory training in falls prevention and assessment.

A review of direct care staff training records for 2017 indicated that 8 of 17 (40%) of registered staff had not completed required training in falls prevention and management in 2017.

In an interview, the Acting Administrator stated that all registered staff should have received annual training in falls prevention and management.

The licensee has failed to ensure that all staff who provided direct care to

residents received, as a condition of continuing to have contact with residents, training in falls prevention and management.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the resident. The scope of the issue was a level 3 as it related to 5 out of 5 areas of training. The home had a level 2 history of unrelated noncompliance.
(522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 216. (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 216 (2).

Order / Ordre :

The licensee must be compliant with s. 216. (2) of O. Reg. 79/10.

Specifically the licensee shall ensure that at least annually, the training and orientation program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that, at least annually, the training and orientation program was evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A review of the home's mandatory training records for 2017 indicated that 51 of 84 (60.7%) of staff had not completed required mandatory training in the following:
The Residents' Bill of Rights;
The home's policy to promote zero tolerance of abuse and neglect of residents;
The duty to make mandatory reports under section 24;
The whistle-blowing protections.

In an interview, the Program Manager (PM) provided information related to the evaluation of the training and orientation program. Upon review of the evaluation there was no date on the evaluation and no signatures at the bottom of the evaluation.

The PM stated although there was some information in the evaluation, there was no documented evidence to support that the evaluation was for 2017, as the document was not signed and there was no date to indicate when the evaluation was actually completed.

In an interview, the Acting Administrator and the Regional Director stated that since there was no date on the evaluation and it was not signed then it was considered not complete for 2017.

The licensee has failed to ensure that, at least annually, the training and orientation program was evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the resident. The scope of the issue was a level 2 as 2 out of 3 programs reviewed did not have an annual evaluation. The home had a level 2 history of unrelated noncompliance. (522)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

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

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

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 18th day of September, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Julie Lampman

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