Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 27, 2014	2014_253514_0018	L-000669-14	Resident Quality Inspection

Licensee/Titulaire de permis

HANOVER NURSING HOME LIMITED
700 19TH AVENUE, HANOVER, ON, N4N-3S6

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

HANOVER CARE CENTRE
700-19TH AVENUE, HANOVER, ON, N4N-3S6

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

RUTHANNE LOBB (514), CHRISTINE MCCARTHY (588), REBECCA DEWITTE (521), SALLY ASHBY (520)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 13, 14, 15, 16, 20, 21, 22, 23, 26, 27, 30, 2014

Inspector(521) joined the RQI team May 15, 16, 20, 21, 22, 2014

During the course of the inspection, the inspector(s) spoke with the Licensee, Administrator, Director of Care, Activation and Life Enrichment Director, 1 Activation Aide, Resident Assessment Instrument Coordinator, 5 Personal Support Workers, 1 Physiotherapy Assistant, 1 Registered Nurse, 2 Registered Practical Nurses, 3 Dietary Aides, 1 Maintenance Worker, 1 Housekeeping Aide, 3 Family Members, 1 Resident Council Representative and 20+ Residents.

During the course of the inspection, the inspector(s) conducted a tour of all resident areas and common areas, observed residents and the care provided to them and observed meal service. Medication administration and storage were observed and clinical records for identified residents were reviewed.Policies and procedures of the home were reviewed along with observation of general maintenance and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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. 8. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times as evidenced by:

LTCH, 2007, c. 8, s. 8 (3) has been the subject of a previous non-compliance WN, VPC issued November 28, 2013 (Inspection #2013_171155_0049).

On May 26, 2014, the Administrator verified that the home does not regularly schedule registered nursing staff to be on duty and present in the home at all times.

A review of the schedule for May 4, 2014-May 31, 2014, a registered nurse was on duty and present in the home 19/56 shifts (34% of the time).

This was confirmed by the Administrator. [s. 8. (3)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident as evidence by:

On May 23, 2014, an audit was completed with 11/42 (26%) of the beds having entrapment concerns.

The Director of Care observed and confirmed the potential entrapment concerns for each bed audited. The Director of Care confirmed that it is the home's expectation that where bedrails are used, steps should be taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The Director of Care confirmed that where bedrails are used, the resident has not been assessed and his or her bed system has not been has not been evaluated to minimize risk to the resident. [s. 15. (1) (a)]

2. The licensee has failed to ensure that the resident has been assessed and his/her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident as evidenced by:

A review of an Incident Report and Nursing Progress notes, revealed a resident incident.
A Registered Practical Nurse confirmed that the staff felt they were doing all that they could do to prevent further identified resident incidents. The Registered Practical Nurse reported that the identified resident had interventions in place to prevent further resident injury.

A Registered Practical Nurse confirmed that the bed was not assessed for safety or entrapment zones before or after the resident incident. [s. 15. (1) (a)]

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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

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:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. O. Reg. 79/10, s. 107 (3) has been the subject of a previous non-compliance WN issued November 28, 2013 (Inspection #2013_171155_0049).

The licensee has failed to ensure that the Director was notified no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital as evidenced by:

Three identified residents sustained injuries that resulted in a significant change in the resident's health condition. On May 20, 2014 and on May 27, 2014, the Administrator verified that the Director was not notified of these incidents and that there were no Critical Incidents submitted to the Director.

The Administrator confirmed the expectation of the home is to report and submit all Critical Incidents to the Director.

2. The licensee failed to include a follow-up action, including the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence following a critical incident as evidenced by:

The Incident Report documentation regarding two identified incidents did not reflect any need to correct the situation and prevent recurrence following the critical incidents.

The home's lack of follow-up actions to correct and prevent recurrence was confirmed by the Resident Assessment Instrument Coordinator. [s. 107. (4) 4.]

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 O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. O. Reg. 79/10, s. 110. (2) has been the subject of a previous non compliance VPC issued November 28, 2013 (Inspection #2013_171155_0049).

The licensee has failed to ensure that staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class as evidenced by:

An audit of 11 residents utilizing restraints in the home revealed that 4/11(36%) did not have approval or an order by a physician or registered nurse in the extended class, and did not have the specific restraint interventions in the plan of care, identified in the home's policy #60-10 Least Restraint Policy.

Identified residents did not have an order by a physician or registered nurse in the extended class, for the use of a specific restraint.

It was verified by a Registered Practical Nurse that the identified residents were using specific restraints and that the home has not progressed to managing these specific restraints yet as the home has been concentrating on getting all the required documentation for other restraints. It was confirmed by the Registered Practical Nurse that the plan of the home is to continue to work on completing the required documentation for all restraints.

The home's policy #110-50 Restraint Program Audit, states that an audit is to be completed quarterly by the Director of Care as per the Quarterly Care Conference Schedule. It was confirmed by a Registered Practical Nurse that the home is not completing a Restraint Program Audit quarterly. [s. 110. (2)]

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. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) 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. O. Reg. 79/10, s. 221 (2).
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. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents, receive training relating to abuse recognition and prevention annually, as evidenced by:

a) On May 27, 2014, the Administrator confirmed that 32/51 (63%) staff completed the abuse training on May 16 and May 28, 2013. Of 51 staff, 19 (37%) staff did not complete the abuse training at that time. The Administrator confirmed that those 19 staff that did not complete the training, still have not completed this 2013 abuse training.

The Administrator revealed that during the abuse training, the staff reviewed the home's Abuse Policy #30-205, revision date October 10, 2012, and the Ministry of Health and Long-Term Care Licensee Reporting of Abuse Decision Trees.

The Administrator confirmed that the home's Abuse Policy #30-205 needs to be revised to be in compliance with current legislation, prior to having the staff complete the 2014 mandatory abuse training.

The Administrator indicated that the home is initiating a web-based education program for their staff's 2014 education needs and estimated that the mandatory abuse training would potentially be ready by end of June 2014. The Administrator confirmed that this mandatory training for 2014 will have exceeded the annual time frame for staff retraining.

b) A Co-op student working with the residents since December 2013 until June 2014 had not received training on the home's policy to promote zero tolerance of abuse and neglect of residents.

c) The annual staff training record for 2013 indicated that 45/51 (88%) staff completed the training to minimize the restraining of residents. Of 51 staff, 6 (12%) staff did not complete the May 16 and May 28, 2013 training at that time. The Administrator confirmed that those 6 staff that did not complete the training, still have not completed this 2013 minimizing the restraining of residents training. [s. 221. (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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with all applicable requirements under the Act; and (b) is complied with as evidenced by:

a) Review of Policy #60-20 Security and Safety - Bedrails/BedRail Covers, revision date May 16, 2005, states that all beds are equipped with full length rails. The type and use of bedrails will be determined according to the individual resident's needs. The use of bedrail covers and pads will be utilized in response to individual needs. Such assessments and needs will be documented on the Resident's Care Plan.

On May 27, 2014, an interview with the Resident Assessment Instrument Coordinator confirmed that all beds are not equipped with full length rails as noted in Policy #60-20 Security and Safety - Bedrails/BedRail Covers, revision date May 16, 2005.

The Resident Assessment Instrument Coordinator confirmed that the policy needs to be updated to reflect the purchase of newer beds.

b) Policy #60-20 Security and Safety - Bedrails/BedRail Covers, revision date May 16, 2005, states: The Clinical nurse will document in the Resident's Care Plan if bedrails are used for individual residents. The Charge Nurse will indicate in the Nurses Notes if the resident becomes at risk of becoming caught in the spaces of the bedrails and what the plan of action will be. The Charge Nurse will ensure that a bedrail pad or cover and/or full length rail is provided for the resident's bed.

The Resident Assessment Instrument Coordinator confirmed that a bedrail pad or cover is not provided for each resident's bed if bedrails are used, and states that Policy #60-20 Security and Safety - Bedrails/BedRail Covers,revision date May 16, 2005, needs to be updated to reflect this procedural change.

c) On May 27, 2014, interview with Resident Assessment Instrument Coordinator revealed that there is no Falls Prevention Policy in the home, identifying ways to reduce the incidence of falls and the risk of injury.

d) Review of Policy #100-150 Resident Services - Hygiene/Mouth Care, revision date December 23, 1998, states that all residents will be given assistance as needed with oral and dental hygiene and denture care a minimum of 3 times daily. A review of the Hanover Care Centre Flow Sheet for the month of May 2014 indicates oral care for four identified residents is documented twice daily. (588)

e) Review of Policy #30-225, Administration - Internal Complaint Procedure, dated April 8, 2013, identifies that "Residence-Written responses will be completed within a reasonable time frame, then returned to chairperson."

On May 26, 2014,an interview with Resident Assessment Instrument Coordinator verified that the policy does not include the legislative requirement of complaints being investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint. (520) [s. 8.]

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 O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury;
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions; 3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable; 4. A pain management program to identify pain in residents and manage pain, as evidenced by:

a) On May 27, 2014, an interview with the Resident Assessment Instrument Coordinator confirmed there is no Falls Prevention Program presently in the home.

b) On May 30, 2014, an interview with a Registered Staff member on May 30, 2014 verified the home does not have the following programs: falls prevention, skin and wound care, continence care and bowel and pain management. [s. 48. (1) 3.]

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure every resident was afforded privacy in treatment and in caring for his or her personal needs as evidenced by:

An resident was observed receiving a medical treatment while in the lounge area, in front of other residents. In discussion with the registered staff it was confirmed that the resident did not receive the required treatment in privacy. [s. 3. (1) 8.]

2. The licensee failed to ensure that the rights of residents were fully respected and promoted: Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On May 15, 2014 resident weights and incontinence status were observed posted on the wall in the tub room. This was verified by the Director of Nursing.

The Director of Care confirmed the home's expectation that every resident has the right to his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act. [s. 3. (1) 11. iv.]

3. The licensee failed to ensure that the following rights of residents are fully respected and promoted. Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act 2007 as evidenced by:

It was observed that the licensee displayed the Licensee Inspection Report, (Inspection Number 2012_091112_0046) in the Public Inspection Reports Binder. The Licensee Report contains the Resident name, symptoms and treatments.

The Administrator verified that the Licensee Copy,(Inspection Number 2012_091112_0046) was in the Public Inspection Reports Binder and confirmed that it is the home's expectation that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act 2007. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her needs and his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act., to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to set out clear directions to staff and others who provide direct care to the resident as evidenced by:

a) On May 21, 2014, a review of the current care plan for an identified resident indicated instructions for a specific medical treatment A review of the physician orders, dated May 7, 2014, stated to discontinue the specific treatment, and this was confirmed by a Registered Practical Nurse. A Registered Practical Nurse confirmed that the current care plan for the identified resident does not reflect the current plan of care.

b) On May 27, 2014, an interview with the Resident Assessment Instrument Coordinator verified that the care plan for an identified resident states the resident will be on a Falls Prevention Program.

The Resident Assessment Instrument Coordinator confirms that the home does not have a Falls Prevention Program and an identified resident is not on a Falls Prevention Program. (520)

c) An interview with the Resident Assessment Instrument Coordinator verified that there is missing documentation, related to bathing for an identified resident in the Hanover Care Centre Continuous Care Flowsheet.

The Resident Assessment Instrument Coordinator confirmed that there were only two days that bathing was documented in reviewed month for an identified resident. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; and that the provision of care, the outcomes and effectiveness of the plan of care is documented., to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Audit done on May 23, 2014, noted the following maintenance concerns:

Room A
Wall damage in bedroom
Wall damage in bathroom
Damage to door frame into bathroom
Dirty/missing caulking base of toilet

Room B
Wall damage in bedroom
Damage to door frame into bathroom

Room C
Wall damage in bedroom
Wall damage in bathroom
Dirty/missing caulking base of toilet
Missing plaster by closet

Room D
Wall damage in bedroom
Wall damage in bathroom
Damage to door frame into bathroom
Wall damage near closet

Room E

Wall damage in bathroom
Damage to door frame into bathroom
Dented and stained heating source near window
Broken and bent blinds in the window

Room F
Wall damage in bathroom
Damage to door frame into bathroom
Dirty/missing caulking base of toilet

Room G
Wall damage in bedroom
Damage to door frame into bathroom
Dirty/missing caulking base of toilet
Heating source cover very hot

Room H
Wall damage in bathroom
Damage to door frame into bathroom

Room I
Wall damage in bedroom (plaster damage)
Wall damage in bathroom
Damage to door frame into bathroom
Dirty/missing caulking base of toilet

Room J
Damage to door frame into bathroom

Room K
Wall damage in bedroom
Damage to door frame into bathroom

Room L
Wall damage in bedroom
Damage to door frame into bathroom
Dirty/missing caulking base of toilet

No heating source in that ward room

Room M
Wall damage in bedroom

Room N
Wall damage behind recliner

Room O
Wall damage in bedroom
Damage to door frame into bathroom

Room P
Wall damage in bathroom
Damage to bathroom door

Room Q
Wall damage in bedroom

Rooom R
Wall damage in bathroom
Damage to door frame into bedroom

The above noted maintenance concerns were verified by the maintenance worker. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres as evidenced by:

a) On May 14, 2014, it was observed that five rooms each had one window able to be opened greater than 15 centimetres. 5/18 (28%) of resident rooms had windows that would open greater than 15 centimetres.

The windows opening greater than 15 centimetres, were viewed and confirmed by the Administrator.

b) It was also observed that the Activity Room had 2 windows able to be opened greater than 15 centimetres; the Lounge had 1 window able to be opened greater than 15 centimetres and the Dining Room had 4 windows able to be opened greater than 15 centimetres.

The Administrator confirmed that these windows were able to be opened greater than 15 centimetres and that the expectation of the home is that windows that open to the outdoors and that are accessible to residents cannot be opened more than 15 centimetres. [s. 16.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls as evidenced by:

An interview with the Resident Assessment Instrument Coordinator revealed that there was no post-falls assessment completed, utilizing a clinically appropriate assessment instrument that is specifically designed for falls, after an identified resident had a fall.

It was confirmed by the Resident Assessment Instrument Coordinator, that there is currently no post-fall assessment being conducted, using a clinically appropriate assessment instrument that is specifically designed for falls, for any resident who has fallen in the home. [s. 49. (2)]

Additional Required Actions:

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

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. The licensee has failed to develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care services, programs and goods provided to residents, as evidenced by:

On May 27, 2014, the Administrator confirmed that the home has not developed and implemented a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care services, programs and goods provided to residents.

The Administrator confirmed that on June 11, 2014 the home is scheduled to have their first Continuous Quality Improvement Committee meeting to initiate goals, objectives, policies, procedures and protocols and a process to identify initiatives for review. [s. 84.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the ventilation system was cleaned and in good state of repair.

This was evidenced by bedroom vents observed to be occluded in five rooms, and bathroom ceiling vents observed to be occluded with thick debris in five rooms. The Medication Preparation room ceiling vent was also occluded with debris.

On May 21, 2014, the occluded vents were verified by the Housekeeping Aide and it was confirmed by the Administrator that the home's expectation is that the ventilation system be cleaned and in good state of repair. [s. 90. (2) (c)]

2. The licensee failed to ensure that procedures are developed and implemented to ensure that all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained as evidenced by soiled caulking around the toilet in an identified room and significant areas of calcification at the base of the sink taps in the Activity room.

This was confirmed by the Maintenance Worker and the Housekeeping Aide. [s. 90. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented to ensure that, (c) ventilation systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure drugs were stored in an area or a medication cart, that was used exclusively for drugs and drug-related supplies as evidenced by:

a) On May 14, 2014, an unlocked and unattended treatment cart was observed, containing inhalers, treatment creams and scissors. A Registered Staff member verified that the expectation of the home is that treatment carts should be locked and confirmed that the treatment cart was unlocked and unattended.

b) On May 15th 2014, a prescribed medication was found on a chair in the lounge by the nurses station. This was confirmed by the Director of Nursing. [s. 129. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Director of Care works regularly in that position on site at the home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week, as evidenced by:

On May 30, 2014 an interview with the Administrator of the home revealed that the Director of Care is not working regularly in that position on site at the home for at least 24 hours per week for the licensed 41 bed facility.

The Administrator confirmed that the Director of Care works full-time at another facility and if she is unable to do the required hours/week one week at the home, that she does additional hours the following week. The Administrator indicated that it was thought that the hours required were based on a per monthly amount and not on a per weekly amount of time.

The Administrator confirmed that the Director of Care does not work at least 24 hours per week at the home.

The Administrator reviewed the Director of Care schedule, dated May 4-31, 2014, with Inspector #514.

On Week 4 of the staffing schedule, dated May 25-31, 2014 it was observed that there were no scheduled Director of Care hours on site.

The Administrator confirmed that the Director of Care was not on site during the week of May 25-31, 2014. [s. 213. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's Director of Nursing and Personal Care works regularly in that position on site, in a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the Infection Prevention and Control program is evaluated and updated at least annually in accordance with evidence-based practices.

This was confirmed by the Administrator. [s. 229. (2) (d)]

2. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program as evidenced by observations of poor caulking around the sink in a resident room. Urine collection containers were found on the floor in the bathroom in a resident room and on the toilet tank in the bathroom in another resident room. There were brown stains on the dented heater in a resident room. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the Infection Control Program and that the program is evaluated and updated at least annually in accordance with evidence-based practices, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident bedroom occupied by more than one resident have sufficient privacy curtains to provide privacy as evidenced by:

An audit of resident rooms and privacy curtains were conducted. 12/12 (100%) rooms did not have privacy curtains that closed around the beds to ensure privacy.

The Director of Care confirmed that the privacy curtains in resident rooms, occupied by more than one resident, did not entirely cover around the residents' beds.

The Director of Care confirmed the home's expectation that each resident room occupied by more than one resident would have sufficient privacy curtains to provide privacy. [s. 13.]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to immediately forward any written complaints that have been received concerning the care of a resident or the operation of the home to the Director.

On February 18, 2014, the licensee received a written complaint concerning the care of a resident. The licensee failed to immediately forward the complaint to the Director.

On May 22, 2014, the Administrator confirmed that the licensee failed to forward the written complaint, received by the home on February 18, 2014, to the Director. [s. 22. (1)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (2) Where the resident was admitted to the home under the Nursing Homes Act, the Charitable Institutions Act or the Homes for the Aged and Rest Homes Act, the licensee shall ensure that a care conference is held in accordance with the following:
1. Where, within 12 months before this section came into force, a conference for the resident was held under subsection 127 (2) of Regulation 832 of the Revised Regulations of Ontario, 1990 (General) made under the Nursing Homes Act, subsection 68 (2) of Regulation 637 of the Revised Regulations of Ontario, 1990 (General) made under the Homes for the Aged and Rest Homes Act or subsection 58 (2) of Regulation 69 of the Revised Regulations of Ontario, 1990 (General) made under the Charitable Institutions Act, a care conference shall be held within 12 months of the last conference. O. Reg. 79/10, s. 27 (2).
2. Where no conference referred to in paragraph 1 was held within 12 months before this section came into force, a care conference shall be held when the resident is reassessed and the resident's plan of care is revised under clause 28 (a). O. Reg. 79/10, s. 27 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference shall be held within 12 months of the last conference as evidenced by:

On May 27, 2014, a review of the clinical record for an identified resident, revealed that there was no recorded annual care conference held within 12 months of the last conference date.

An interview with the Resident Assessment Instrument Coordinator verified that there was no record of an annual care conference for an identified resident in 2013.

The Resident Assessment Instrument Coordinator further confirmed the expectation of the home is to have annual care conferences for all residents. [s. 27. (2)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items, as evidenced by:

On May 15, 2014 personal care items were observed to be unlabelled in the spa room.

On May 15, 2014, it was confirmed by the Director of Care, that the home's expectation is that personal care items be labelled within 48 hours of admission and of acquiring, in the case of new items. [s. 37. (1)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear as evidenced by:

The home received a written complaint from a family member of a resident. The complaint stated that on two identified dates, a resident was found in soiled clothing. The complainant identified that the resident remained in soiled clothing for a number of hours, despite family requesting staff intervention.

It was confirmed by the Director of Care that the resident had remained in soiled clothing on these identified dates and that it is the home's expectation that residents in the home shall be assisted with getting dressed as required, dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. [s. 40.]

WN #23: 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 respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations as evidenced by:

On May 27, 2014, a review of Resident Council Meeting minutes of April 29, 2013-April 30, 2014 revealed:

a) On February 27, 2014 Resident Council Meeting minutes identified concerns, with a response from the Administration, that was not dated or signed by the Administration.

b) On July 29, 2013, August 28, 2013, and January 29, 2014 Resident Council Meeting Minutes identified concerns, with a response from the Administration, that was not dated by the Administration.

The Life Enrichment Director reviewed and confirmed the missing dates and signatures of the above noted Resident Council Meeting Responses. [s. 57. (2)]

WN #24: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's actions based on the results of the home's annual survey of the residents and their families, measuring their satisfaction with the home,the care, services, programs and goods provided, are made available to residents and their families as evidenced by:

On May 27, 2014, the Administrator confirmed that there were no actions taken to improve the home, the care, services, programs and goods provided, based on the survey results from the 2013 survey. [s. 85. (4) (c)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee failed to ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have

been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

c) identifies measures and strategies to prevent abuse and neglect;

d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

e) identifies the training and retraining requirements for all staff, including, (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and (ii) situations that may lead to abuse and neglect and how to avoid such situations, as evidenced by:

On May 22, 2014, the home's Abuse Policy (#30-205 Administrative Services - Abuse Policy, revision date October 10, 2012) was reviewed and it was noted to contain a Purpose Statement, Definitions of Abuse and a Procedure for Reporting and Investigating Abuse.

Policy #30-205 failed to:

(a) contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

c) identify measures and strategies to prevent abuse and neglect;

d) identify the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

e) identify the training and retraining requirements for all staff, including, (i) training on the relationship between power imbalances between staff and residents and the

potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and (ii) situations that may lead to abuse and neglect and how to avoid such situations.

The Administrator confirmed the Abuse Policy is not compliant with the current legislation. [s. 96. (a)]

WN #26: 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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has a response within 10 business days of the receipt of the complaint as evidenced by:

The licensee received a written complaint on February 18, 2014 from a family member regarding the care of a resident. The licensee responded in writing to the complainant on March 11, 2014.

It was confirmed by the Administrator and the Director of Care that this written response to the complainant, dated March 11, 2014, exceeded the required response within 10 business days of receipt of the complaint. [s. 101. (1) 1.]

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

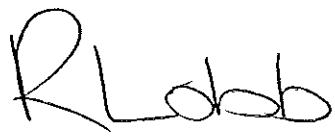
Findings/Faits saillants :

1. The licensee has failed to ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents are communication to the Residents' Council as evidenced by:

On May 27, 2014, the Administrator and the Life Enrichment Director confirmed that the home does not currently ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents are communicated to the Residents' Council. The Administrator confirmed that they are working on initiating a Continuous Quality Improvement Program which will result in enhanced communication with Residents' Council. [s. 228. 3.]

Issued on this 30th day of June, 2014

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



Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RUTHANNE LOBB (514), CHRISTINE MCCARTHY (588), REBECCA DEWITTE (521), SALLY ASHBY (520)
Inspection No. / No de l'inspection :	2014_253514_0018
Log No. / Registre no:	L-000669-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 27, 2014
Licensee / Titulaire de permis :	HANOVER NURSING HOME LIMITED 700 19TH AVENUE, HANOVER, ON, N4N-3S6
LTC Home / Foyer de SLD :	HANOVER CARE CENTRE 700-19TH AVENUE, HANOVER, ON, N4N-3S6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BRENDA WEPPLER

To HANOVER NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Grounds / Motifs :

1. LTCH, 2007, c. 8, s. 8 (3) has been the subject of a previous non-compliance WN, VPC issued Nov 28, 2013 (Inspection #2013_171155_0049).

The licensee has failed to ensure that there is at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times except as provided for in the regulations, as evidenced by:

An Interview with the Administrator on May 26, 2014, verified that the home does not have a registered nurse on duty and present in the home at all times.

A review of the schedule for May 4, 2014-May 31, 2014, revealed a registered nurse was on duty and present in the home 19/56 shifts (34% of the time).

This was confirmed by the Administrator.
(520)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 24, 2014

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 : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 15 (1) to ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability.
Please submit the plan in writing to Ruthanne Lobb, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th floor, London ON N6A 5R2, by email, at Ruthanne.Lobb@ontario.ca by August 15, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident has been assessed and his/her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident as evidenced by:

a) Incident Report and Nursing Progress notes, recorded an incident that was documented for an identified resident who sustained an injury.

A Registered Practical Nurse confirmed that the staff felt they were doing all that they could for the identified resident and interventions were in place for the identified resident to prevent injury with the bed system. A Registered Practical Nurse confirmed that the bed was not assessed for safety or entrapment zones before or after the resident incident.

b) On May 23, 2014, an audit was completed showing 11/42 (26%) of the beds with entrapment concerns.

The Director of Care observed and confirmed the potential entrapment concerns for each bed audited. The Director of Care confirmed that it is the home's expectation that where bed rails are used, steps should be taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The Director of Care confirmed that where bedrails are used, the resident had not been assessed and his/her bed system had not been evaluated to minimize risk to the resident.

(514)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 24, 2014

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 : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
3. A missing or unaccounted for controlled substance.
4. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Order / Ordre :

The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

Grounds / Motifs :

1. O. Reg. 79/10, s. 107 (3) has been the subject of a previous non-compliance WN issued Nov 28, 2013 (Inspection #2013_171155_0049).

The licensee has failed to ensure that the Director was notified no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital as evidenced by:

a) Three identified residents had three separate incidents which resulted in a significant change in the residents' conditions. On May 20, 2014 and on May 27, 2014 the Administrator verified that the Director was not notified of these incidents and that there were no Critical Incidents submitted following the incidents. The Administrator confirmed the expectation of the home is to report and submit all Critical Incidents to the Director.

(520)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 22, 2014

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Order / Ordre :

The licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. 2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.

Grounds / Motifs :

1. O. Reg. 79/10, s. 110. (2) has been the subject of a previous non compliance WN, VPC issued Nov 28, 2013 (Inspection #2013_171155_0049).

The licensee has failed to ensure that staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class as evidenced by:

On May 30, 2014, an audit of 11 residents utilizing restraints in the home revealed that 4/11(36%) did not have approval or an order by a physician or registered nurse in the extended class, and did not have the specific restraint interventions in the plan of care, identified in the home's policy #60-10 Least Restraint Policy.

Four identified residents did not have an order by a physician or registered nurse in the extended class, for the use of restraints.

It was verified by a Registered Practical Nurse that the identified residents are using specific restraints . It was confirmed by the Registered Practical Nurse that "the plan of the home is to continue to work on completing the required documentation for these specific restraints".

(514)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 24, 2014

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 : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (2) 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.
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. O. Reg. 79/10, s. 221 (2).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 221 (2) to ensure 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.
Please submit the plan in writing to Ruthanne Lobb, Long-Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th floor, London ON N6A 5R2, by email at Ruthanne.Lobb@ontario.ca, by August 15, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff who provide direct care to residents, receive training relating to abuse recognition and prevention annually, as evidenced by:

a) On May 27, 2014, the Administrator confirmed that 32/51 (63%) staff completed the abuse training on May 16 and May 28, 2013. Of 51 staff, 19 (37%) staff did not complete the abuse training at that time. The Administrator confirmed that those 19 staff that did not complete the training, still have not completed this 2013 abuse training.

The Administrator revealed that during the abuse training, the staff reviewed the home's Abuse Policy #30-205, revision date October 10, 2012 and the Ministry of Health and Long-Term Care Licensee Reporting of Abuse Decision Trees.

The Administrator confirmed that the home's Abuse Policy #30-205 needs to be revised to be in compliance with current legislation, prior to having the staff complete the 2014 mandatory abuse training.

The Administrator indicated that the home is initiating a web-based education program for their staff's 2014 education needs and estimated that the mandatory abuse training would potentially be ready by end of June 2014. The Administrator confirmed that this mandatory training for 2014 will have exceeded the annual time frame for staff retraining.

b) A student working with the residents since December 2013 until June 2014 had not received training on the home's policy to promote zero tolerance of abuse and neglect of residents.

c) The annual staff training record for 2013 indicate that 45/51 (88%) staff completed the training to minimize the restraining of residents. Of 51 staff, 6 (12%) staff did not complete the May 16 and May 28, 2013 training at that time. The Administrator confirmed that those 6 staff that did not complete the training, still have not completed this 2013 minimizing the restraining of residents training.
(514)

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 24, 2014

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 : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg 79/10,s. 8. (1) to ensure where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with all applicable requirements under the Act; and (b) is complied with.
Please submit the plan in writing to Ruthanne Lobb, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th floor, London ON N6A 5R2, by email, at Ruthanne.Lobb@ontario.ca, by August 15, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with all applicable requirements under the Act; and (b) is complied with as evidenced by:

a) Review of Policy #60-20 Security and Safety - Bedrails/BedRail Covers, revision date May 16, 2005, states that all beds are equipped with full length rails. The type and use of bedrails will be determined according to the individual resident's needs. The use of bedrail covers and pads will be utilized in response to individual needs. Such assessments and needs will be documented on the Resident's Care Plan.
Policy #60-20 Security and Safety - Bedrails/BedRail Covers procedure states: The Clinical nurse will document in the Resident's Care Plan if bedrails are used for individual residents. The Charge Nurse will indicate in the Nurses Notes if the

resident becomes at risk of becoming caught in the spaces of the bedrails and what the plan of action will be. The Charge Nurse will ensure that a bedrail pad or cover and/or full length rail is provided for the resident's bed.

b) On May 27, 2014, an interview with the Resident Assessment Instrument Coordinator confirmed that all beds are not equipped with full length rails as noted in Policy #60-20 Security and Safety - Bedrails/BedRail Covers. The Resident Assessment Instrument Coordinator indicated that the policy needs to be updated to reflect the purchase of newer beds.

The Resident Assessment Instrument Coordinator confirmed that a bedrail pad or cover is not provided for each resident's bed if bedrails are used and states that Policy #60-20 Security and Safety - Bedrails/BedRail Covers needs to be updated to reflect that this procedural change.

c) On May 27, 2014, interview with Resident Assessment Instrument Coordinator revealed that there is no Falls Prevention Policy in the home, identifying ways to reduce the incidence of falls and the risk of injury.

d) Review of Policy #100-150 Resident Services - Hygiene/Mouth Care, revision date December 23, 1998, states that all residents will be given assistance as needed with oral and dental hygiene and denture care a minimum of 3 times daily. A review of the Hanover Care Centre Flow Sheet for the month of May 2014 indicates oral care for four identified residents is documented twice daily. (514)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 24, 2014

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) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.
O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 48 (1).
The plan must ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. 2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. 3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. 4. A pain management program to identify pain in residents and manage pain.
Please submit the plan in writing to Ruthanne Lobb, Long-Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th floor, London ON N6A 5R2, by email at Ruthanne.Lobb@ontario.ca, by August 30, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. 2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. 3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. 4. A pain management program to identify pain in residents and manage pain as evidenced by:

An interview with a Registered Staff member on May 30, 2014 at 1130 hours verified the home does not have the following programs: falls prevention, skin and wound care, continence care and bowel and pain management. (520)

2. The licensee has failed to ensure that a falls prevention and management program is implemented in the home to reduce the incidence of falls and the risk of injury as evidenced by:

Interview with the Resident Assessment Instrument Coordinator on May 27, 2014, at 1100 hours, confirmed there is no Falls Prevention Program presently in the home. (520)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 24, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board

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

and the Director

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 27th day of June, 2014

Signature of Inspector / Signature de l'inspecteur : 

Name of Inspector / Nom de l'inspecteur : Ruthanne Lobb

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