Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 10, 2016	2016_269627_0021	026784-16	Resident Quality Inspection

Licensee/Titulaire de permis

HORNEPAYNE COMMUNITY HOSPITAL
278 FRONT STREET P.O. BOX 190 HORNEPAYNE ON P0M 1Z0

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

HORNEPAYNE COMMUNITY HOSPITAL
278 FRONT STREET P.O. BOX 190 HORNEPAYNE ON P0M 1Z0

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

SYLVIE BYRNES (627), JULIE KUORIKOSKI (621)

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): September 13-16, 2016.

Additional logs inspected during the RQI included:

A follow up intake (032853-15), CO#1 related to policies, and CO#2 related to staff education.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Activity Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and their families.

The Inspector(s) conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' health care records, staff training records, policies and programs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 76. (7)	CO #002	2015_320612_0015	627

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home’s Restraint policy was complied with, as ordered in Inspection 2015_320612_0015, compliance order (CO) #001.

CO #001 was issued to address failure to comply with O.Reg. 79/10, s. 8 (1).

The compliance order required the licensee to ensure that the home's Restraint policy and Falls Prevention policy were complied with. During the inspection, the home was found to be compliant with their Falls Prevention policy; however, the Restraint policy was not complied with.

During stage one of the inspection, Inspector #627 observed an identified resident to have a specific restraint.

Inspectors #621 and #627 observed the identified resident with a restraint engaged.

Inspector #621 reviewed the home's Restraint policy titled "Physical/Chemical/Environmental Restraints", (no revision date), which stated that all residents admitted to long-term care would have a restraint assessment done using the "Interdisciplinary Restraint Assessment Form". Additionally, any restraints that were implemented for a resident would be reassessed and documented by the interdisciplinary team at least quarterly on the "Interdisciplinary Restraint Assessment Form". The policy also identified that the home ensured that restraints would not be used as a first step in management of a resident's safety, but rather as part of a graduated set of interventions.

During an interview with the Inspector, a particular RN stated that the identified resident used a restraint. During the same interview, Inspector #621 inquired if the home had documented an assessment of this resident’s restraint needs on admission, quarterly, or when resident's care needs changed with respect to restraint requirements. The particular RN stated to the Inspector that no formal assessment or reassessment had been documented as part of the plan of care for the identified resident, or any other resident with respect to assessment of their restraint needs.

During an interview with the Inspector, the Director of Care (DOC) stated that the home had not completed an assessment of restraint needs for residents on admission, and that the home did not have an interdisciplinary restraint assessment form to complete restraint assessments on admission, as per policy. Additionally, the DOC identified that

registered nursing staff had not reviewed or reassessed restraint needs quarterly or when resident needs changed using the interdisciplinary restraint assessment form, as indicated in the policy. The DOC also reported that the home did not have a formalized process to document what alternatives to restraints were assessed with residents before deciding to use a restraint. [s. 8. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to were kept closed and locked.

During stage one of the inspection, Inspectors #621 and #627 conducted a tour of the home. The Inspectors observed that an exit door, which was accessible to the residents, located on the unit between the DOC's office and resident rooms was unlocked. The Inspectors were able to exit the building and access the parking lot of the home through the unlocked door. The Inspectors further observed the same door unlocked during the consecutive days of the inspection.

During an interview with Inspector #621, the DOC stated that the exit door on the unit that accessed the parking lot outside was kept closed, but was not locked as per legislative requirements. [s. 9. (1) 1. i.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, be kept closed and locked, to be implemented voluntarily.

WN #3: 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 were used, residents were assessed and their bed systems were evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the residents.

Inspector #621 reviewed and identified resident's plan of care, including the electronic health record, and paper chart, and no evidence of a completed bed rail risk assessment was found.

During an interview with the Inspector, a particular RN reported to Inspector #621 that registered staff had not completed a bed rail risk assessment for the identified resident.

2. Inspector #621 observed an identified resident in bed with two bed rails raised and engaged.

A particular RPN and the Inspector observed the identified resident asleep in bed, with one bed rail raised and engaged.

During an interview with Inspector #621, the identified resident stated that they used a bed rail when in bed.

Inspector #621 reviewed the identified resident's plan of care, including the electronic health record, and paper chart, and found no evidence of a completed bed rail risk assessment.

During an interview with the Inspector, a particular RN stated that the identified resident used a bed rail when in bed. They further stated that registered staff had not completed a bed rail assessment for the identified resident.

3. On a certain date, during stage one of the inspection, Inspector #627 observed one bed rail raised and engaged on an identified resident's bed.

Two days later, Inspector #621 observed one bed rail raised and engaged on the identified resident's bed.

Inspector #621 reviewed the identified resident's plan of care, including the electronic health record, and paper chart, and found no evidence of a completed bed rail risk assessment.

During an interview with Inspector #621, the identified resident stated that they occasionally used the bed rail when in bed.

During an interview with the Inspector, a particular RN stated that the identified resident at times had put the bed rail up on their own. They further stated that that registered staff did not complete bed rail risk assessments.

During an interview with the Inspector, the DOC confirmed that the home had not completed bed rail risk assessments or bed system evaluations when residents were admitted, at quarterly reviews or when resident care needs changed, and confirmed that the identified residents had not had a bed rail risk assessment completed or a bed system evaluation done.

A memo from the Ministry of Health and Long-Term Care (MOHLTC) dated August21, 2012, was sent to all Long-Term Care (LTC) Home Administrators indicating that all LTC homes should use the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards' as a best practice document in their homes. This document referenced the 'Clinical Guidance for the Assessment and implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings' (CGA), as a prevailing practice for the assessing the use of bed rails. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used a resident is assessed and their bed system is evaluated in accordance with Health Canada guidance document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospital, Long Term Care Facilities, and Home Care Settings" as evidenced best practice, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Skin and Wound Care Program was evaluated and updated at least annually in accordance with evidence-based practice and if there are none, in accordance with prevailing practices.

During stage one of the inspection, Inspector #627 observed an identified resident with a wound for which they had received treatment.

During an interview with Inspector #627, a particular RN stated that the policy titled "Braden Scale", last revised October 1, 2014, was the policy and the Skin and Wound Care Program that staff referred to for wound prevention and treatment.

During an interview with the Inspector, the DOC confirmed that the policy titled "Braden Scale", last revised on October 1, 2014, was their current Skin and Wound Care Program. They further confirmed that the program had not been evaluated or updated annually. [s. 30. (1) 3.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During stage one of the inspection, Inspector #627 observed an identified resident with a wound for which they had received treatment.

Inspector #627 reviewed a progress note that documented that the identified resident had received a specific type of treatment for a specific type of wound.

A review of the Long Term Care Doctor's order sheet revealed the following:
New standing order for skin tear dressing orders (discontinue all previous orders).

During an interview with the Inspector, a particular RN stated that when a resident sustained a wound, a "Record of Wound Status" form was to be initiated. This provided for an initial assessment of the wound and for weekly reassessments until the wound was healed. The "Record of Wound Status" form was kept with the Medication Administration Record (MAR). A review of the MAR, by the Inspector and the particular RN failed to reveal a "Record of Wound Status" form for the current wound. The particular RN stated that since the identified resident often had this type of wound, the staff were aware of the standing Doctor's orders and had provided the care but had not initiated a "Record of Wound Status" form. the particular RN confirmed that a "Record of Wound Status" should have been completed when the wound occurred and that the wound should have been reassessed weekly using the "Record of Wound Status" form.

During an interview with the Inspector, the DOC stated that any resident who developed a wound should have had an initial assessment done using the "Record of Wound Status" form and that all weekly reassessments were to be documented on this form. The form was to be kept with the MAR. The DOC confirmed that a "Record of Wound Status" should have been initiated when the identified resident sustained a wound. [s. 50. (2) (b) (i)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the inspection reports from the past two years were posted in the home, in a conspicuous and easily accessible location.

During the initial tour of the home, in stage one of the inspection, Inspector #621 and #627 noted that there were no public inspection reports posted in the home. A notice was posted in a display case on the wall of the unit next to the exit doors which indicated that the inspection reports could be viewed in the Resident and Family Information Binder located in the Long-Term Care Lounge. During an observation of the Long-Term Care Lounge area of the home, Inspector #621 failed to locate a copy of the Resident and Family Information Binder.

A review of the home's Compliance History Report for the previous two years revealed that two Resident Quality Inspections had been completed.

During an interview with Inspector #621, the DOC stated that they made a decision to take down the home's inspection reports that were posted in a glass display case on the unit and place them instead in a black binder titled "Resident and Family Information Binder". The DOC identified that this binder was placed in the common room of the unit for residents to access, with a notice posted in the glass display case as to where residents, their families, and the public could locate the binder. However, the DOC stated that they later had made a decision to move the binder from the common room to the resident services room. The inspection reports were available to residents, families and the public upon request to a staff member. [s. 79. (3) (k)]

Issued on this 25th day of November, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SYLVIE BYRNES (627), JULIE KUORIKOSKI (621)
Inspection No. / No de l'inspection :	2016_269627_0021
Log No. / Registre no:	026784-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 10, 2016
Licensee / Titulaire de permis :	HORNEPAYNE COMMUNITY HOSPITAL 278 FRONT STREET, P.O. BOX190, HORNEPAYNE, ON, P0M-1Z0
LTC Home / Foyer de SLD :	HORNEPAYNE COMMUNITY HOSPITAL 278 FRONT STREET, P.O. BOX190, HORNEPAYNE, ON, P0M-1Z0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Heather Jaremy-Berube

To HORNEPAYNE COMMUNITY HOSPITAL, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_320612_0015, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the home's Restraint policy is complied with by ensuring that:
1) All residents admitted to the long-term care home have a restraint assessment done using the "Interdisciplinary Restraint Assessment Form".
2) Any restraints that are implemented for a resident, are reassessed and documented by the interdisciplinary team at least quarterly on the "Interdisciplinary Restraint Assessment Form".
3) Ensure that restraints are not used as a first step in management of a resident's safety, but rather as part of a graduated set of interventions which shall be documented.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the home's Restraint policy was complied with, as ordered in Inspection 2015_320612_0015, compliance order (CO) #001.

CO #001 was issued to address failure to comply with O.Reg. 79/10, s. 8 (1).

The compliance order required the licensee to ensure that the home's Restraint policy and Falls Prevention policy were complied with. During the inspection, the home was found to be compliant with their Falls Prevention policy; however, the

Restraint policy was not complied with.

On a certain date, during stage one of the inspection, Inspector #627 observed an identified resident to have a specific restraint.

Two days later, Inspectors #621 and #627 observed the identified resident with a restraint engaged.

Inspector #621 reviewed the home's Restraint policy titled "Physical/Chemical/Environmental Restraints", (no revision date), which stated that all residents admitted to long-term care would have a restraint assessment done using the "Interdisciplinary Restraint Assessment Form". Additionally, any restraints that were implemented for a resident would be reassessed and documented by the interdisciplinary team at least quarterly on the "Interdisciplinary Restraint Assessment Form". The policy also identified that the home ensured that restraints would not be used as a first step in management of a resident's safety, but rather as part of a graduated set of interventions.

During an interview with the Inspector, a particular RN stated that the identified resident used a restraint. During the same interview, Inspector #621 inquired if the home had documented an assessment of this resident's restraint needs on admission, quarterly, or when resident's care needs changed with respect to restraint requirements. The particular RN stated to the Inspector that no formal assessment or reassessment had been documented as part of the plan of care for the identified resident, or any other resident with respect to assessment of their restraint needs.

During an interview with the Inspector, the Director of Care (DOC) stated that the home had not completed an assessment of restraint needs for residents on admission, and that the home did not have an interdisciplinary restraint assessment form to complete restraint assessments on admission, as per policy. Additionally, the DOC identified that registered nursing staff had not reviewed or reassessed restraint needs quarterly or when resident needs changed using the interdisciplinary restraint assessment form, as indicated in the policy. The DOC also reported that the home did not have a formalized process to document what alternatives to restraints were assessed with residents before deciding to use a restraint. [s. 8. (1)]

The decision to re-issue this compliance order was based on the severity which

indicated a potential for harm and the scope which was widespread. Despite a compliance order issued in Inspection 2015_320612_0015, non compliance continues with the original area of non compliance.
(621)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 10th day of November, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sylvie Byrnes

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