Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 18, 2018;	2018_737640_0020 (A1)	015192-18	Resident Quality Inspection

Licensee/Titulaire de permis

King Nursing Home Limited
49 Sterne Street Bolton ON L7E 1B9

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

King Nursing Home
49 Sterne Street Bolton ON L7E 1B9

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

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Amended by HEATHER PRESTON (640) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The Licensee requested extension to CDD for CO #s001, #002, #004 and #005.

Issued on this 18 day of October 2018 (A1)

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

Original report signed by the inspector.

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

Amended by HEATHER PRESTON (640) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): June 27, 28, 29, July 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19 and 20, 2018.

During the course of the inspection, the following Critical Incident intakes were inspected:

Intake #009096-17, related to resident to resident physical aggression

Intake #011107-17, related to resident self harm

Intake #013974-17, related to alleged resident to resident sexual abuse

Intake #014920-17, related to alleged resident to resident sexual abuse

Intake #024848-17, related to resident to resident physical aggression

Intake #017203-18, related to staff to resident allegation of abuse

Intake #026365-17, related to resident to resident physical aggression

Intake #029459-17, related to failure to report laboratory results

Intake #004618-18, related to resident to resident physical aggression

Intake #005189-18, related to resident fall with injury

Intake #008899-18, related to respiratory outbreak

Intake #009135-18, related to respiratory outbreak

Intake #021655-17, related to a fall with injury

Intake #028689-17, related to alleged resident to resident physical abuse

During the course of the inspection, the following complaints were inspected:

Intake #000505-18 related to continence care, heating concerns

Intake #000697-18 related to care concerns

Intake #001603-18 related to care concerns, heating, housekeeping

Intake #001656-18 related to housekeeping, continence care and other care concerns

Intake #029765-17 related to housekeeping, continence care and other care concerns

Intake #006150-18 related to care planning concerns

Intake #018040-18, related to concerns about care

During the course of the inspection the following follow-ups to Compliance Orders was conducted:

Intake #007845-18 related to prevention of abuse of residents Compliance Order #001 issued under Inspection #2018_724640_0007

Intake #007846-18 related to responsive behaviour assessments and interventions Compliance Order #002 issued under Inspection #2018_724640_0007

During the course of the inspection the inspectors toured the home, observed the provision of care and services, reviewed relevant documents including but not limited to: clinical records, policies and procedures and meeting minutes, observed housekeeping practices and observed infection prevention and control practices.

During the course of the inspection, the inspector(s) spoke with residents, family members, personal support workers (PSW), housekeepers, maintenance worker, dietary aides, recreation aides, registered practical nurses (RPN), registered nurses (RN), Behavioural Support Ontario (BSO) RPN, Clinical Quality Coordinator, Environmental Manager, Nutritional Manager, Director of Family and Resident Services, Physiotherapist, agency staff, Falls Lead, Skin and Wound Care Lead, Continence Care Lead, Infection Prevention and Control Lead, Office Manager, Assistant Director of Care, the Director of Care and the Administrator.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Training and Orientation

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

22 WN(s)
11 VPC(s)
5 CO(s)
2 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).
(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).
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

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 :

The licensee 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 was specifically designed for skin and wound assessment.

1.On an identified date in September 2017 resident #007 was found on the floor. During an assessment by the RN #101, they complained of pain. The resident was transferred to a higher level of care facility for further assessment.

When the resident returned to the home they had altered skin integrity.

There were no clinically appropriate skin assessments found in the clinical record by the Long-Term Care Homes (LTCH Inspector.

During an interview with the home's Wound and Skin Lead, they told the LTCH Inspector it was an expectation of the home that a skin assessment of all altered skin integrity was to have been completed by staff.

The DOC acknowledged the home had not assessed the altered skin integrity using the home's clinically appropriate assessment instrument specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)] (640)

2. The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a) During stage 1 of the Resident Quality Inspection (RQI), resident #001 triggered for altered skin integrity.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record and found the resident had been diagnosed with altered skin integrity since admission.

The home's policy "Skin and Wound Care Management Protocol", policy #VII-

G-10.80 with a revised date of July 2015, directed staff to initiate a weekly skin assessment for a resident who exhibited altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds.

The LTCH Inspector reviewed resident #001's clinical record which revealed that there were several weekly skin assessments that were documented in the Treatment Administration Record (TAR) in March, April and June 2018 as being completed but there was no evidence of any documented weekly skin assessment on several dates in the three months reviewed.

During an interview with RN #101, the home's Skin and Wound Care Lead, they stated that weekly skin assessments using the home's Skin and Wound Assessment form located in the home's electronic records were expected to be completed for this type of altered skin integrity.

The LTCH Inspector and the RN reviewed the weekly skin assessment records for the months of March, April and June 2018.

RN #101 acknowledged the home did not complete the required weekly skin assessments for resident #001's altered skin integrity on specific dates.

b) Review of a critical incident report dated in March 2018, reported resident #009 was transferred to a higher level of care facility due to an injury.

Review of resident #009's clinical record, an initial wound care assessment was completed on an identified date in March 2018, which identified the altered skin integrity
and no further skin assessments were conducted thereafter.

Interview with RPN #107 acknowledged that the home's practice was to complete a weekly skin assessment, assess any skin integrity impairment and that a weekly skin assessment was not completed for resident #009's altered skin integrity.

c) Resident #012 returned to the home on an identified date in February 2018, following a procedure.

At the time of the inspection the initial altered skin integrity had healed, but other areas had been identified.

During an interview of RPN #138, they indicated that resident #012 was to have weekly skin assessments completed.

The Director of Care (DOC) and the Long-Term Care Homes (LTCH) Inspector reviewed dates on Treatment Administration Record (TAR) that were signed as a skin and wound assessment being completed for the months of June and July 2018. Those dates were then cross referenced with the progress notes where the assessment notes were to be documented, for the same or near dates.

The TAR directed that weekly skin/treatment assessment were to be completed for specific dates in June and July 2018. All dates had been signed by registered staff as completed.

Assessments that the DOC verified that were found as completed were for two of the required eight dates.

The DOC acknowledged staff documented on the TAR that a weekly skin assessment was completed but had not been for the identified dates. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

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

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the licensee must ensure that;
a) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to provide for an annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision makers (SDM) and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts were negotiated or renegotiated.

During an inspection related to continence care, the Long-Term Care Homes (LTCH) Inspector requested the annual evaluation of the residents' satisfaction

survey of the continence care products from the Assistant Director of Care (ADOC), the Continence Program Lead.

The ADOC had a few completed surveys, which were handed to the LTCH Inspector stating they struggled to get substitute decision makers (SDM) to complete the survey. The surveys initially given to the LTCH Inspector were all completed by staff.

The LTCH Inspector reviewed the completed forms and requested the evaluation of the surveys from the ADOC. At this time, the ADOC had a few resident surveys to include with the staff surveys. There were no family surveys noted in the selection provided.

The ADOC stated they were just typing up a summary of the surveys which had not been previously completed.

The ADOC acknowledged there was no evaluation of the annual resident satisfaction survey of the continence care products completed for the calendar year 2017. [s. 51. (1) 5.]

2. The licensee failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

a) During stage 1 of the Resident Quality Inspection (RQI), resident #006 triggered for incontinence as identified in the most recent Minimum Data Set (MDS) assessment. The Long-Term Care Homes (LTCH) Inspector reviewed the MDS assessment which assessed the resident to require extensive assistance of one person for toileting and was frequently incontinent of bladder.

During an interview with resident #006, they informed the LTCH Inspector of their toileting preferences and usual routines.

PSW #106, the resident's primary care provider, stated the resident's care needs changed from time to time. The resident was not on a scheduled toileting plan.

The home's policy "Continence Program – Promoting Continence", policy #VII-D-10.10 with a revised date of January 2015, directed staff to adhere to the

resident's individualized care plan to include scheduled times for checking, changing and toileting residents based on resident specific toileting regime.

The resident's plan of care in place at the time of the inspection did not include an individualized toileting plan based on the assessed needs of the resident.

During an interview with RPN #113, they acknowledged that resident #006 was not on an individualized toileting plan.

b) During stage 1 of the Resident Quality Inspection (RQI), resident #001 triggered for incontinence as identified in the most recent Minimum Data Set (MDS) assessment.

The Long-Term Care Homes (LTCH) Inspector reviewed the MDS assessment and they were assessed to require extensive assistance of one person for toileting and was frequently incontinent of bladder.

During an interview with resident #001, they informed the LTCH Inspector of their toileting preferences and usual routines.

PSW #106, the resident's primary care provider, stated the resident's care needs changed from time to time. The resident was not on a scheduled toileting plan.

The resident's plan of care in place at the time of the inspection did not include an individualized toileting plan based on the assessed needs of the resident.

During an interview with RPN #105, they acknowledged that resident #001 did not have an individualized plan to manage and promote bladder continence.

c) Resident #030 was assessed to be incontinent of urine and used an incontinent product.

The Assistant Director of Care (ADOC), the home's Continence Care Lead, stated to the Long-Term Care Homes (LTCH) Inspector that it was expected that all resident's, regardless of cognition and continence history, were to have a three day voiding diary completed upon admission and an individualized toileting plan based on that diary developed and implemented.

There was no evidence that a three day voiding diary had been completed at

admission or any other time to determine the resident's individualized needs and patterns related to voiding.

During an interview with the ADOC, they acknowledged the written plan of care did not include an individualized plan to promote and manage resident #030's urinary continence.

d) Resident #028 was admitted to the home and had multiple medical diagnosis.

The clinical record for resident #028 was reviewed by the Long-Term Care Homes (LTCH) Inspector and indicated that a three day voiding diary and a bowel and bladder assessment was completed which identified the resident's continence care needs.

RPN #111 told the LTCH Inspector that there was no individualized plan of care in place to promote and manage bowel and bladder continence for resident #028.

During an interview with the Associate Director of Care (ADOC), they stated their expectation was that upon admission, a three day voiding diary was to be completed for each resident and if the resident was incontinent then an individualized toileting plan was expected to be developed.

The Director of Care (DOC) told the LTCH Inspector that there was no individualized toileting plan in place for resident #028.

They acknowledged that resident #028 did not have an individualized plan of care in place to promote and manage their bowel and bladder continence. [s. 51. (2) (b)]

Additional Required Actions:

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

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure, as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that there were schedules and procedures in place for routine, preventive and remedial maintenance.

The Long-Term Care Homes (LTCH) Inspector was informed there were flies in the first floor dining room and in the first floor shower. A maintenance request was submitted electronically.

After reviewing the photograph of the flies by the LTCH Inspector #120, it was determined that these were drain flies. When drains were not sealed, or the "P" traps were dried out or broken or when drains had not been cleaned for a long time, this caused too much debris to be housed in the drain such as hair and faeces, causing the drain flies to breed in the material. Every long-term care home was required to have in place, processes and procedures to ensure all of their floor

drains were maintained such as being cleaned out and in good condition to prevent insects from breeding in them.

The LTCH Inspector interviewed the maintenance person who said they had not been asked to clean any drains nor were they aware that any drains had been cleaned during the past eight months.

The LTCH Inspector reviewed the home's policy "Preventative Maintenance Program", policy # V-C-10.00 and "Preventative Maintenance Monthly Administration Report", policy #V-C-10.00 (b), with a revised date of January 2015, which did not include any schedule or procedures in place for the routine, preventive or remedial maintenance of any drains in the home.

During an interview with the Environmental Manager (EM), they were not aware of any contracted service or any process in place related to the maintenance of the drains.

During an interview with the Administrator, they acknowledged the home did not have any process or procedure in place for routine, preventive or remedial maintenance of the floor drains in the home. [s. 90. (1) (b)]

2. The licensee failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair.

On an identified date July 2018, observations were made by the Long-Term Care Homes (LTCH) Inspector for resident #004 and during one of the observations it was noted that the resident's specialized chair was not in good repair. RPN #104 told the LTCH Inspector that it had been broken for several days.

Resident #004's clinical record indicated that the resident received a loaner chair. The resident had been using the chair for several days and there was no documentation of it being in disrepair.

During an interview with PSW #116 and RPN #111, they stated that maintenance was responsible for repairing any loaner chair as it was owned by the home.

The home's policy "Work Order Requisitions", policy #V-A-10.10 with a revised date of January 2015, directed that the home was to utilize the automated work

requisition system (Gynor) to request maintenance repairs to ensure that the physical plant, building, equipment, and furnishings were maintained in good condition. It also indicated that all staff were to complete an online requisition with a full description of the work requested.

RPN #115 acknowledged that resident #004's specialized chair had been in disrepair for a few days and no maintenance requisition had been sent.

The Environmental Manager (EM) told the LTCH Inspector the home was responsible for maintenance of any loaner equipment that were provided by the home and staff were expected to send in a maintenance requisition once they became aware of the issue.

The home failed to ensure that procedures were implemented to ensure that resident #004's specialized chair was kept in good repair. [s. 90. (2) (b)]

Additional Required Actions:

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

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the licensee must ensure that procedures are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Review of CI report submitted to the Ministry of Health and Long Term Care (MOHLTC) reported resident to resident abuse. The CI report stated that on several dates in July 2017 resident #015 inappropriately touched multiple co-residents, some were observed and witnessed by staff. According to co-resident's clinical records, most were not able to give consent.

The progress notes stated the Director of Resident and Family Services (DRFS) spoke with resident #015 and explained to the resident that their actions of inappropriately touching other residents were inappropriate.

There were multiple incidents that occurred where resident #015 displayed responsive behaviours towards other residents. The home's interventions were ineffective and did not prevent continued incidents from happening.

During interviews with RPNs #113, #107, and #138, they told the Long-Term Care Homes (LTCH) Inspector that resident #015 had responsive behaviours. The intervention in place was to monitor and keep resident #015 away from other residents.

During an interview with the BSO RPN, they told the LTCH inspector that the resident was monitored using Dementia Observational System (DOS) and was referred to specific health care professional for further follow up.

The licensee failed to ensure that residents were protected from abuse from resident #015. [s. 19. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 004

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions.

Review of CI report submitted to the Ministry of Health and Long Term Care (MOHLTC) reported resident to resident abuse. The CI report stated that on several identified dates in July 2018, resident #015 inappropriately touched resident #017.

Documentation in resident #015's progress notes after the resident was admitted, stated that the home began noticing the resident to have responsive behaviours of inappropriate action toward other residents.

On several identified dates in July 2017, resident #015 was witnessed by staff inappropriately touching several co-residents.

The progress notes stated the DRFS spoke with resident #015 and explained to the resident that touching other residents was inappropriate.

Review of resident #015’s plan of care continued to have the same interventions of monitoring the resident’s behaviours and intervening only after resident #015 had already touched a resident. There were numerous incidents that occurred where resident #15 displayed responsive behaviours towards other residents and that the interventions were ineffective and did not prevent the incidents from happening.

During interviews with RPNs #113, #107, and #138, they told the Long-Term Care Homes (LTCH) Inspector that resident #015 had responsive behaviours and the interventions were to monitor and keep resident #015 away from other residents.

During an interview with the BSO RPN, they indicated that resident #015 had displayed responsive behaviours that were inappropriate towards other residents. They stated that the resident was monitored using Dementia Observational System (DOS) and was referred to special services for further follow up.

The licensee failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions. [s. 53. (4) (c)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 005

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #6: The Licensee has failed to comply with LTCHA, 2007, 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

The clinical record for resident #013 was reviewed and indicated that an assessment was completed by the home's Physiotherapist (PT), who made recommendations for use of a specific Personal Assistance Services Device (PASD) for comfort and positioning.

Resident #013's written plan of care did not include any information regarding the use of the specific PASD.

The PT told the LTCH Inspector that registered staff were expected to update the plan of care for the use of PASD. They further added that there was no written care plan for the use of the PASD for resident #013.

During an interview with RPN #117 and PSW #118, they acknowledged that there was no written plan of care for the use of the PASD for resident #013.

The home failed to ensure that there was a written plan of care for the use of the PASD for the resident that set out the planned care for the resident. [s. 6. (1) (a)]

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

On an identified date in May 2017, resident #027 had verbalized to the PSW of taking action on an inappropriate responsive behavior. The staff immediately implemented Dementia Observational System (DOS). On an identified date in May 2017, staff heard a noise near resident #027's bed and staff noticed the resident had sustained an injury.

The home's policy "Responsive Behaviour Management", policy #VII-F-10.20 with a revised date of January 2015, directed staff that the needs of residents was to be met using an interdisciplinary approach to screening, assessment, reassessment, and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental, or other, and to determine the occurrence, frequency and duration of responsive behaviour concerns.

The DOC was to determine the need for additional staffing supports. The registered staff were to document in the individualized plan of care any measures to identify level of risk and report any changes.

The LTCH Inspector reviewed the clinical record with the home's Behavioural Supports Ontario (BSO) RPN. Specifically the written plan of care was reviewed. It was noted the plan of care did not include the specific diagnosis and was not

reviewed and revised to include the residents' new occurrence of a certain behaviour and any relevant interventions to respond to their needs.

The BSO RPN acknowledged that strategies were expected to be developed and implemented to respond to the specific behaviours and included in the resident's plan of care based on the resident's care needs that had changed and this had not occurred. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance The licensee must ensure;
a) that there is a written plan of care for each resident that set out the planned care for the resident,
b) that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary,
c) that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the care set out in the plan is not effective and,
d) that when a resident is reassessed and the plan of care reviewed and revised, if the plan of care is being revised because care set out in the plan is not effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.

In accordance with Ontario Regulation 79/10, s.48, required the licensee to ensure that the interdisciplinary programs including falls prevention and management, were developed and implemented in the home and each program must meet the requirements as set out in section 30. Each program must have a written description of the program that included its goals and objectives and relevant policies, procedures and protocols to meet the requirements as set out in section 30. O. Reg. 79/10, s.48

i) On an identified date in November 2017 resident #029 sustained two unwitnessed falls.

The home's policy "Head Injury Routine", policy #VII-G-10.40 (b), with a revised date of January 2015, directed staff to initiate a head injury routine (HIR) with any unwitnessed head injury or fall. The process of the HIR was to continue based on a pre-set schedule for 24 hours following the unwitnessed fall.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record for resident #029, and it included HIR documentation form which had been initiated and completed for the first fall. The second unwitnessed fall did not have the HIR initiated or completed as per the home's policy.

During an interview with RN #134, the Falls Prevention Lead for the home, they acknowledged that HIR was not initiated and continued as per the policy following the second fall.

ii) Review of a CI report, resident #009 was transferred to a higher level of care following a specific injury.

Review of resident #009's progress notes indicated the resident was diagnosed with a specific diagnosis and the medical instructions provided directed that the resident was to have specific interventions for 24 hours.

Review of resident #009's Head Injury Routine (HIR) records stated that HIR for three occasions during was not completed.

Interview with RPN #100 and RN #126 stated that when a resident was on a HIR, the procedure was for the resident to be assessed at each required time.

The licensee failed to follow the home's Head Injury Routine policy for resident #009. s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, (a) can be easily seen, accessed and used by residents, staff and visitors at all times.

During the RQI inspection, the Long-Term Care Homes (LTCH) Inspector along with housekeeping staff #137 and RPN #104 observed one specific tub and shower room where the call bell cords were not accessible for a resident or staff to reach.

During an interviews with RPN #104 and housekeeping staff #137, they told the LTCH Inspector they were aware call bells should always be accessible to them and the residents.

During an interview with the Director of Care (DOC), they stated that call bells must be accessible to the residents and staff and acknowledged that the call bell cords were not accessible. [s. 17. (1) (a)]

2. The licensee failed to ensure that the resident-staff communication and response system was available in every area accessible by residents.

During the RQI Inspection, Long-Term Care Homes (LTCH) Inspectors #696 and #606 identified that there were no call bells in the dining rooms and lounge areas on all the floors.

PSW #127 and #128 confirmed that there were no call bells in the dining rooms and lounge areas.

Home's policy titled "Nurse Call System" dated January 2015, stated that every licensee of a long-term care home shall ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

During an interview with Director of Care (DOC), they acknowledged that there were no call bells in the dining rooms and lounge areas.

The home failed to ensure that the resident-staff communication and response system was available in every area accessible by residents, specifically, in the dining rooms and lounge areas. [s. 17. (1) (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance The licensee must ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

As a result of an inspection regarding pain management for resident #012, the Long-Term Care Homes (LTCH) Inspector reviewed the resident's clinical record.

The resident returned to the home following a specific procedure. Medication orders included routine narcotic analgesic with an available routine analgesic for uncontrolled pain.

On an identified date in February 2018, an assessment tool was implemented for 72 hours.

The home's policy "Pain and Symptom Management", policy # VII-G-30.10 with a revised date of February 2018, directed staff to complete a pain assessment electronically when a resident reported or exhibited signs and symptoms of pain greater than 4/10 for 24 to 48 hours following implementation of pharmacological and/or non-pharmacological interventions (satisfactory pain relief was not achieved following interventions).

During the month of April and June 2018, the resident's required their as needed (prn) narcotic analgesic numerous times over a several week period as a result of moderate to high pain scores.

Review of the clinical record did not identify any clinically appropriate pain assessment being completed for any of the noted dates and times.

During an interview with the Assistant Director of Care (ADOC), they stated that if a pain score was consistently greater than 4/10 for a minimum of 24 hours, staff were expected to complete a pain assessment under the assessment tab in PointClickCare, the home's electronic documentation system.

The DOC acknowledged that staff do not complete a clinically appropriate pain assessment when a resident's pain was not relieved with initial interventions. [s. 52. (2)]

Additional Required Actions:

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

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

a) As per a Critical Incident System (CIS) report, on an identified date in October

2017 resident #014 came out of their room and exhibited behaviour toward resident #025.

Resident #014's progress notes were reviewed and it was documented that on numerous occasions resident #014 exhibited specific behaviours towards resident #025.

On a few occasions a Responsive Behaviour Referral was made and specific interventions were developed.

There was no documentation in resident #014's clinical records to support that any of the interventions were implemented when resident #014 exhibited behaviour towards resident #025.

The home's policy "Responsive Behaviours-Management", policy #VII-F-10.20 with a revised date of January 2015, directed that registered staff were to coach front-line staff about interventions identified on the care plan and to strategize with them on additional interventions required or on the effectiveness of interventions.

During the interview with BSO RPN, they acknowledged that interventions were not implemented to manage resident #014's responsive behavior towards resident #025. They further added that interventions should have been implemented to minimize the risk of harmful interactions between the residents.

The home failed to ensure that procedures and interventions were implemented to minimize the risk of altercations and potentially harmful interactions between the residents.

b) Review of a CI Report that reported resident #015 demonstrated inappropriate behaviour towards resident #016.

Review of resident #015's progress notes stated that resident #046 reported to staff that they witnessed resident #015 exhibiting inappropriate behaviour towards resident #016.

The progress notes indicated that staff informed the Director of Resident and Family Services (DRFS) who followed up with resident #015 to explain to them that their actions were not appropriate.

The documentation stated that resident #015 continued to act inappropriately toward several other residents.

There were no other interventions or strategies put in place to address the behaviours.

Review of resident #015's written plan of care indicated the resident was identified with behavioural risk characterized by inappropriate behaviours towards other residents. It directed staff to monitor the resident and intervene immediately and to inform resident #015 that their actions are inappropriate

There was no revisions or updates to resident #015's plan of care regarding the inappropriate incidents.

Interviews with RPNs #113, #107, and #138 stated that resident #015 had responsive behaviours toward other residents and that the interventions in the plan of care directed staff to monitor and keep resident #015 away from the other residents.

The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents. [s. 55. (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 the licensee must ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training in the areas mentioned below:

a) The Resident's Bill of Rights.
b) The long-term care home's mission statement.
c) The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
d) The duty under section 24 to make mandatory reports.
e) The protections afforded by section 26.
f) The long-term care home's policy to minimize the restraining of residents.
g) Fire prevention and safety.
h) Emergency and evacuation procedures.
i) Infection prevention and control.
j) All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that were relevant to the person's responsibilities.
k) Any other areas provided for in the regulations.

In accordance with section 2 (1) of the LTC Homes Act 79/10, "staff", in relation to a long-term care home, means persons who work at the home, (a) as employees of the licensee, (b) pursuant to a contract or agreement with the licensee, or (c) pursuant to a contract or agreement between the licensee and an employment agency or other third party.

1) The Long-Term Care Homes (LTCH) Inspector observed a person wearing a uniform and no name tag or other identification, standing in the hallway at shift change on an identified date in July 2018. When asked who they were, they told the LTCH Inspector they were a personal support worker (PSW) from an agency.

The LTCH Inspector noted the point-of-care (POC) documentation tool was open and had resident's personal health information showing and there were no other staff present. The LTCH Inspector pointed the POC screen out to agency PSW #124. The PSW did not seem to understand the importance or what they were to do.

The LTCH Inspector asked the PSW when they received their orientation to the home. PSW #124 stated that this was their first time in the home and had not had any orientation or training prior to the shift.

2) A second agency PSW #125 was assigned to provide care to one particular resident on an identified date in July 2018. When asked when their orientation had occurred at the home, they stated they have not had any orientation at this home.

The day prior was their first time in the home to provide care to an individual resident.

The home's policy "Onboarding", policy #III-C-10.00 with a revised date of March 2015, directed that, to ensure the safe and successful onboarding of all staff, including agency staff, the Organization was to provide an effective onboarding experience within a timely manner, in compliance with all applicable legislation and their mission, vision and values. The policy stated the employee was to complete specific components to include mandatory legislated learning and information and when applicable, participate in and complete position – specific onboarding processes.

During an interview with the Office Manager, the person responsible for scheduling, they did not know the name of the agency PSW that had been assigned. They stated they only call the agency to obtain PSW coverage. They did not have in their possession or have access to the approved list of PSWs from the agency that had received the appropriate orientation and training prior to being scheduled. They stated one was not provided to them.

During an interview with the Director of Care (DOC), they told the LTCH Inspector that when they could not cover a shift with their own staff, they use agency PSWs. As a last resort, they use agency PSWs who had not attended the required orientation and training. The home normally used the agency PSW who had not had any orientation for one to one direct care.

The DOC acknowledged PSW #124 and #125 had not had the required orientation and training prior to working at the home and should not have been scheduled. [s. 76. (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 the licensee must ensure that no person mentioned in subsection (1) perform their responsibilities before receiving training in the areas mentioned below:

a) The Resident's Bill of Rights.
b) The long-term care home's mission statement.
c) The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
d) The duty under section 24 to make mandatory reports.
e) The protections afforded by section 26.
f) The long-term care home's policy to minimize the restraining of residents.
g) Fire prevention and safety.
h) Emergency and evacuation procedures.
i) Infection prevention and control.
j) All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that were relevant to the person's responsibilities.
k) Any other areas provided for in the regulations.

In accordance with section 2 (1) of the LTC Homes Act 79/10, "staff", in relation to a long-term care home, means persons who work at the home, (a) as employees of the licensee, (b) pursuant to a contract or agreement with the licensee, or (c) pursuant to a contract or agreement between the licensee and an employment agency or other third party, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) drugs were stored in an area or a medication cart, (i) that was used exclusively for drugs and drug-related supplies, and (ii) that was secure and locked.

The Long-Term Care Homes (LTCH) Inspector observed with RPN #113 on an identified date in July 2018, a tote on the counter at the nursing station containing prescription treatment creams and ointments belonging to several residents without any registered staff present.

During an interview with RPN #113, they stated that the treatment creams were given to the PSWs to administer to the residents during morning care and that when the PSWs had administered the treatment creams to the residents, the treatment creams were returned to the tote at the nursing station. The RPN acknowledged that medications such as prescription treatment creams and ointments should have been stored in the medication room and not left unattended at the nursing station.

During an interview with the Director of Care (DOC), they stated that treatment creams and ointments were medications and should have been stored and locked in the medication room and not left at the nursing station unattended. [s. 129. (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 the licensee must ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies and that is secure and locked, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of the home's medication errors for the last quarter, dated April to June 2018 was completed and a medication error involving resident #031 was reviewed and inspected.

Review of resident #031's medication incident report indicated a tablet was discovered in a medication cup in resident #031's blue medication bin in the medication cart by the registered staff member working on an identified date in June 2018.

Review of resident #031's physician order stated the resident was to be administered one tablet of the identified medication three times a day.

Review of resident #031's electronic Medication Administration Record (e-MAR), RPN #129 documented that resident #031 was administered the medication but according to a medication incident report stated the resident did not receive the one dose.

During an interview with the Director of Care (DOC), they acknowledged that a tablet was discovered in a medication cup in the medication cart and that it had not been administered to the resident as prescribed by the physician. [s. 131. (2)]

Additional Required Actions:

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

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
2. Residents must be offered immunization against influenza at the appropriate time each year. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the Infection Prevention and Control program.

a) On an identified date in July 2018 during an observation of a meal service, the Long-Term Care Homes (LTCH) Inspector observed hand hygiene was not completed by the following staff members; PSWs #109, #122, #108, and RPN #135, during the time that they were feeding/assisting different residents. Further observations by the LTCH Inspector noted that residents #009, #010, #022, #044, #045, and #030 were brought into the dining room and out of the dining room after their meal without staff offering and/or providing any of the residents hand hygiene.

During interviews with PSW #109 and RPN #135, they stated that they were to use disposable wipes to wipe the residents' hands and face/mouth after their meals and today there were no wipes available.

RPN #135 indicated they were not aware of the issue that the floor did not have

any wipes available. They stated today the residents observed did not receive hand hygiene before and/or after the resident finished their meal. They further stated that the home's practice was for staff to wash their hands before and after they had provided care to a resident and acknowledged they did not follow the home's practice.

During an interview with the Assistant Director of Care (ADOC), the home's Infection Prevention and Control (IPAC) lead, they stated that the home's practice was for staff to wash their hands before and after care. The ADOC acknowledged that staff had not participated in the implementation of the infection prevention and control program.

b) During the RQI Inspection, the LTCH Inspector along with housekeeping staff #137 and PSW #136 observed the tub room with an unlabelled black comb noted with strands of hair and debris; the LTCH Inspector observed with housekeeping staff #137 and RPN #104 in a different tub room, an unlabelled white bar of soap with dried soap scum, sitting on the shelf, and the following day the LTCH Inspector observed in the shared resident bathroom, an unlabelled toothbrush with some of the toothbrush bristles noted to be blackish brown in colour on the sink just behind the faucet.

During an interview with PSW #136, RPN #104 and the DOC, they acknowledged that personal care items belonging to residents such as the black comb, toothbrush, and the white bar of soap must be labelled and were not.

The licensee failed to ensure that that all staff participated in the implementation of the IPAC program. [s. 229. (4)]

2. The licensee failed to ensure that the following immunization and screening measures were in place: 2. Residents must be offered immunization against influenza at the appropriate time each year.

During Stage 1 of the Resident Quality Inspection (RQI), a family member reported that resident #028 did not receive their identified immunization as requested.

Review of resident #028's progress notes stated the resident was admitted and gave consent for the resident to receive an identified vaccine. Further review of resident #028s progress notes indicated there was a physician's order for the resident to receive the vaccine.

During an interview with the ADOC, they acknowledged that the resident should have received the immunization and did not. [s. 229. (10) 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 the licensee must ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director, 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

1) The home submitted a Critical Incident report to the Director related to resident to resident abuse, stating that nursing staff found resident #014 had caused specific injury to resident #024.

Review of the home's risk management tab in Point Click Care (PCC), resident #014 and #024's charts, and the home's investigation notes were completed and there was no written documentation to support that home had immediately reported the incident of abuse that occurred.

The home's policy "Prevention of Abuse & Neglect of a Resident", policy #V-A-10.10 with a revised date of January 2015, directed that all employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents, and families were required to immediately report any suspected or known incident of abuse or neglect to the Director. Abuse was defined as: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident."

During an interview with Director of Care (DOC), they acknowledged that this incident was considered a resident to resident abuse and that they were aware that such incidents needed to be reported immediately to the Director. They confirmed that this incident occurred but a report wasn't submitted immediately to the Director.

The home failed to ensure that resident to resident abuse that resulted in harm to resident #024 was immediately reported to the Director.

2) During a review of a Critical Incident report by the Long-Term Care Homes (LTCH) Inspector, it was noted the Director was not immediately informed regarding the abuse of resident #047.

The Director was notified 24 hours after the incident.

During an interview with the Director of Care they acknowledged the home did not immediately report the incident of abuse to the Director. [s. 24. (1)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
4. Vision. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 4. Vision.

During stage one of the Resident Quality Inspection (RQI), resident #010 was identified as visually impaired according the the most recent Minimum Data Set (MDS) assessment.

Review of resident #010's written plan of care did not indicate any interventions to manage the resident's visual impairment.

During an interview with RPN #107, they stated that resident #010 was identified as visually impaired and there should have been a focus and interventions to address their vision included in the plan of care.

The licensee failed to ensure that a plan of care was based on an interdisciplinary assessment of resident #010's vision impairment. [s. 26. (3) 4.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 29. Every licensee of a long-term care home shall ensure that when a resident is reassessed and the resident's plan of care is reviewed and revised under subsection 6 (10) of the Act, any consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that Act, that is relevant, including a regulated document under paragraph 2 of subsection 227 (1) of this Regulation, is reviewed and, if required, revised. O. Reg. 79/10, s. 29.

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident was reassessed and the resident's plan of care was reviewed and revised under subsection 6 (10) of the Act, any consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that Act, that was relevant, including a regulated document under paragraph 2 of subsection 227 (1) of this Regulation, was reviewed and, if required, revised.

During an interview with RPN #113, they told the LTCH Inspector that resident #006 refused their medication frequently. As a result, staff were directed in the plan of care, based on physician orders, to use an alternative method of administration of the medication. The RPN could not confirm or find evidence to support that the resident or substitute decision maker (SDM) gave consent for this to occur.

The LTCH Inspector reviewed the clinical record and was not able to find consent.

The home's policy "Authorization of Personal Assistance and Consent to Treatment", policy #VIII-C-10.40 with a revised date of January 2015, directed staff they must obtain consent from the resident or SDM before treatment was given. It also directed staff to obtain consent for any new treatment and document in the progress notes.

The DOC acknowledged the home did not obtain consent for the change in treatment for medications. [s. 29.]

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

Specifically failed to comply with the following:

s. 30. (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 failed to ensure that the following was 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: 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. 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).

a) During an interview with the DOC, they stated that the home did not complete an annual evaluation of the home's personal support services program for 2017 and therefore did not have any documentation to provide the LTCH inspector to review.

b) During a review of the annual evaluation of the Continence Care and Bowel Management program dated June 28, 2018, the Long-Term Care Homes (LTCH) Inspector noted there was one change made to the program captured in the minutes with no date associated with the implementation.

During an interview with the Director of Care (DOC), they acknowledged the list of changes made was not completed and the date the change was implemented was not included in the report.

The licensee failed to ensure that the following was 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: 3. The program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices and 4. Keep a written record of each evaluation to include the date of the evaluation, the names of the persons who participated, a summary of the changes made and the date that those changes were implemented. [s. 30. (1) 4.]

WN #19: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a Personal Assistance Service Device (PASD) under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if: the use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker (SDM) of the resident with authority to give that consent.

During stage 1 of the Resident Quality Inspection (RQI), resident #013 triggered for incorrect application of a device.

The clinical record for resident #013 was reviewed by the Long-Term Care Homes (LTCH) Inspector and it indicated that an assessment was completed by the home’s Physiotherapist (PT), who made recommendations for use of a specific PASD for positioning.

There was no documentation in resident #013’s clinical record to indicate that a consent was received from the resident’s SDM for the use of PASD.

The home's policy "Personal Assistance Service Devices (PASD’s)”, with a policy # VII-E-10.10 with a revised date of November 2015, directed that registered staff were to obtain and document consent for the use of PASD from a resident/SDM on the Restraints/PASD electronic assessment form. A Restraints/PASD consent form may also be used. It also directed that an annual renewal of the consent by the resident/SDM of the PASD was required.

During an interview with RPN #117, they acknowledged that no consent was received from resident #013’s SDM for the use of the PASD.

The home failed to ensure that the use of a PASD had been consented to by the resident #013’s SDM. [s. 33. (4) 4.]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that that an interdisciplinary team, which included the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who was a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and recommend any changes necessary to improve the system

Review of a document entitled, "Quality Management-LTC Program/Committee Evaluation Tool", Medication Management, dated June 28, 2018, for the period reviewed of May 2017 to May 2018 which stated it did not include the Administrator.

During an interview with the Director of Care (DOC), they acknowledged that the Administrator had not participated in the annual review of the medication management program. [s. 116. (1)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Review of the home's medication errors for the last quarter, dated April to June 2018, was completed and a medication error involving resident #031 was reviewed and inspected.

Review of resident #031 medication incident report indicated a controlled substance was discovered in a medication cup in resident #031 blue medication bin in the medication cart by an RPN. Further review of the medication incident report stated that the physician was not notified of the medication error.

During an interview with RN #129 and the DOC, they stated that the resident's physician was not notified of the medication error. [s. 135. (1)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 235. Records of current staff

Specifically failed to comply with the following:

s. 235. (1) Subject to subsection (2), every licensee of a long-term care home shall ensure that the records of current staff members are kept at the home. O. Reg. 79/10, s. 235 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the records of current staff members were kept at the home.

During a Resident Quality Inspection (RQI), the Long-Term Care Homes (LTCH) Inspector requested an employee file.

In the presence of LTCH Inspectors #606 and #696, the Administrator gave LTCH Inspector #640 a brown file folder containing documents and stated they did not know where the employee file was. They thought the employee file may be at the bookeeper's office.

On a second date the LTCH Inspector requested the employee file from the Administrator. The Administrator stated they had not asked about the location of the employee file.

The Administrator acknowledged they did not keep the employee file in the home at all times.

The licensee failed to ensure that all current employee files were kept at the home. [s. 235. (1)]

Issued on this 18 day of October 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Central West Service Area Office
500 Weber Street North,
WATERLOO, ON, N2L-4E9
Telephone: (888) 432-7901
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WATERLOO, ON, N2L-4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

Amended Public Copy/Copie modifiée du public de permis

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

Inspection No. / No de l'inspection : 2018_737640_0020 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 015192-18 (A1)

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

Report Date(s) / Date(s) du Rapport : Oct 18, 2018;(A1)

Licensee / Titulaire de permis : King Nursing Home Limited
49 Sterne Street, Bolton, ON, L7E-1B9

LTC Home / Foyer de SLD : King Nursing Home
49 Sterne Street, Bolton, ON, L7E-1B9

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Janice King

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To King 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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must comply with s. 50 (2) of O. Reg. 79/10.

Specifically the licensee must:
a) Ensure that resident's #001, #009 and #012 and any other resident exhibiting altered skin integrity, receive weekly assessments by a member of the registered staff, to include all skin breakdown, pressure ulcers, skin tears and wounds.

Grounds / Motifs :

1. The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a) During stage 1 of the Resident Quality Inspection (RQI), resident #001 triggered for altered skin integrity.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record and found the resident had been diagnosed with altered skin integrity since admission.

The home's policy "Skin and Wound Care Management Protocol", policy #VII-G-10.80 with a revised date of July 2015, directed staff to initiate a weekly skin assessment for a resident who exhibited altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds.

The LTCH Inspector reviewed resident #001's clinical record which revealed that there were several weekly skin assessments that were documented in the Treatment Administration Record (TAR) in March, April and June 2018 as being completed but there was no evidence of any documented weekly skin assessment on several dates in the three months reviewed.

During an interview with RN #101, the home's Skin and Wound Care Lead, they stated that weekly skin assessments using the home's Skin and Wound Assessment form located in the home's electronic records were expected to be completed for this type of altered skin integrity.

The LTCH Inspector and the RN reviewed the weekly skin assessment records for the months of March, April and June 2018.

RN #101 acknowledged the home did not complete the required weekly skin assessments for resident #001's altered skin integrity on specific dates.

b) Review of a critical incident report dated in March 2018, reported resident #009 was transferred to a higher level of care facility due to an injury.

Review of resident #009's clinical record, an initial wound care assessment was completed on an identified date in March 2018, which identified the altered skin integrity and no further skin assessments were conducted thereafter.

Interview with RPN #107 acknowledged that the home's practice was to complete a weekly skin assessment, assess any skin integrity impairment and that a weekly skin assessment was not completed for resident #009's altered skin integrity.

c) Resident #012 returned to the home on an identified date in February 2018, following a procedure.

At the time of the inspection the initial altered skin integrity had healed, but other areas had been identified.

During an interview of RPN #138, they indicated that resident #012 was to have weekly skin assessments completed.

The Director of Care (DOC) and the Long-Term Care Homes (LTCH) Inspector reviewed dates on Treatment Administration Record (TAR) that were signed as a skin and wound assessment being completed for the months of June and July 2018. Those dates were then cross referenced with the progress notes where the assessment notes were to be documented, for the same or near dates.

The TAR directed that weekly skin/treatment assessment were to be completed for specific dates in June and July 2018. All dates had been signed by registered staff as completed.

Assessments that the DOC verified that were found as completed were for two of the required eight dates.

The DOC acknowledged staff documented on the TAR that a weekly skin

assessment was completed but had not been for the identified dates. [s. 50. (2) (b) (iv)]

The severity of this issue was determined to be a level 2, minimal harm or potential for actual harm. The scope of the issue was level 2, pattern. The home had a level 4 compliance history, ongoing non-compliance despite previous action taken by the Ministry that included:

- a Voluntary Plan of Correction (VPC) issued October 16, 2017 during inspection #2017_482640_0018

(606)

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

Nov 02, 2018(A1)

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee must be compliant with s. 51 (2) of O. Reg. 79/10.

Specifically the licensee must:
a) Ensure that resident's #001, #006, #028 and #030 and any other resident have a continence assessment completed to include obtaining information about the resident's bladder routine using a clinically appropriate assessment instrument specifically designed for the assessment of continence, and based on that assessment, develop and implement an individualized toileting plan to promote and manage their bowel and bladder continence.

Grounds / Motifs :

1. The licensee failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

a) During stage 1 of the Resident Quality Inspection (RQI), resident #006 triggered for incontinence as identified in the most recent Minimum Data Set (MDS) assessment. The Long-Term Care Homes (LTCH) Inspector reviewed the MDS assessment which assessed the resident to require extensive assistance of one person for toileting and was frequently incontinent of bladder.

During an interview with resident #006, they informed the LTCH Inspector of their toileting preferences and usual routines.

PSW #106, the resident's primary care provider, stated the resident's care needs changed from time to time. The resident was not on a scheduled toileting plan.

The home's policy "Continence Program – Promoting Continence", policy #VII-D-10.10 with a revised date of January 2015, directed staff to adhere to the resident's individualized care plan to include scheduled times for checking, changing and toileting residents based on resident specific toileting regime.

The resident's plan of care in place at the time of the inspection did not include an individualized toileting plan based on the assessed needs of the resident.

During an interview with RPN #113, they acknowledged that resident #006 was not on an individualized toileting plan.

b) During stage 1 of the Resident Quality Inspection (RQI), resident #001 triggered for incontinence as identified in the most recent Minimum Data Set (MDS) assessment.

The Long-Term Care Homes (LTCH) Inspector reviewed the MDS assessment and they were assessed to require extensive assistance of one person for toileting and was frequently incontinent of bladder.

During an interview with resident #001, they informed the LTCH Inspector of their toileting preferences and usual routines.

PSW #106, the resident's primary care provider, stated the resident's care needs changed from time to time. The resident was not on a scheduled toileting plan.

The resident's plan of care in place at the time of the inspection did not include an individualized toileting plan based on the assessed needs of the resident.

During an interview with RPN #105, they acknowledged that resident #001 did not have an individualized plan to manage and promote bladder continence.

c) Resident #030 was assessed to be incontinent of urine and used an incontinent product.

The Assistant Director of Care (ADOC), the home's Continence Care Lead, stated to the Long-Term Care Homes (LTCH) Inspector that it was expected that all resident's, regardless of cognition and continence history, were to have a three day voiding diary completed upon admission and an individualized toileting plan based on that diary developed and implemented.

There was no evidence that a three day voiding diary had been completed at admission or any other time to determine the resident's individualized needs and patterns related to voiding.

During an interview with the ADOC, they acknowledged the written plan of care did not include an individualized plan to promote and manage resident #030's urinary

continence.

d) Resident #028 was admitted to the home and had multiple medical diagnosis.

The clinical record for resident #028 was reviewed by the Long-Term Care Homes (LTCH) Inspector and indicated that a three day voiding diary and a bowel and bladder assessment was completed which identified the resident's continence care needs.

RPN #111 told the LTCH Inspector that there was no individualized plan of care in place to promote and manage bowel and bladder continence for resident #028.

During an interview with the Associate Director of Care (ADOC), they stated their expectation was that upon admission, a three day voiding diary was to be completed for each resident and if the resident was incontinent then an individualized toileting plan was expected to be developed.

The Director of Care (DOC) told the LTCH Inspector that there was no individualized toileting plan in place for resident #028.

They acknowledged that resident #028 did not have an individualized plan of care in place to promote and manage their bowel and bladder continence. [s. 51. (2) (b)]

The severity of this issue was determined to be a level 2, minimal harm or potential for actual harm. The scope of the issue was a level 3, widespread. The home had a level 4 compliance history, ongoing non-compliance despite previous action taken by the Ministry that included:

- a Voluntary Plan of Correction (VPC) was issued August 19, 2015 during inspection #2015_275536_0015

(640)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Nov 30, 2018(A1)

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

The licensee must be compliant with s. 90 (1) of O. Reg. 79/10.

Specifically the licensee must:
a) Ensure there are schedules and procedures in place for routine, preventive and remedial maintenance of all floor drains in the home.

Grounds / Motifs :

1. The licensee failed to ensure, as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that there were schedules and procedures in place for routine, preventive and remedial maintenance.

The Long-Term Care Homes (LTCH) Inspector was informed there were flies in the first floor dining room and in the first floor shower. A maintenance request was submitted electronically.

After reviewing the photograph of the flies by the LTCH Inspector #120, it was determined that these were drain flies. When drains were not sealed, or the "P" traps were dried out or broken or when drains had not been cleaned for a long time, this caused too much debris to be housed in the drain such as hair and faeces, causing the drain flies to breed in the material. Every long-term care home was required to have in place, processes and procedures to ensure all of their floor drains were maintained such as being cleaned out and in good condition to prevent insects from breeding in them.

The LTCH Inspector interviewed the maintenance person who said they had not been asked to clean any drains nor were they aware that any drains had been cleaned during the past eight months.

The LTCH Inspector reviewed the home's policy "Preventative Maintenance Program", policy # V-C-10.00 and "Preventative Maintenance Monthly Administration Report", policy #V-C-10.00 (b), with a revised date of January 2015, which did not include any schedule or procedures in place for the routine, preventive or remedial maintenance of any drains in the home.

During an interview with the Environmental Manager (EM), they were not aware of any contracted service or any process in place related to the maintenance of the drains.

During an interview with the Administrator, they acknowledged the home did not have any process or procedure in place for routine, preventive or remedial maintenance of the floor drains in the home. [s. 90. (1) (b)]

The severity of this issue was determined to be a level 2, minimal harm or potential for actual harm. The scope of the issue was level 3, widespread. The home had a level 4 compliance history that included:

- A Director's Order made under O. Reg. 79/10, s. 90 (1), was issued under

inspection #2017_482640_0025, served January 29, 2018 with a compliance due date of April 13, 2018.

- The follow up inspection related to the Director's Order to O. Reg. 79/10, s. 90 (1) under #2018_539120_0020, conducted on May 1, 2018, resulted in findings of non-compliance with Item #4 of the Director's Order. As a result, a Compliance Order #001 under the LTCHA, s. 101 (3) was served May 25, 2018 with a compliance due date of September 1, 2018.
(640)

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

Oct 10, 2018

Order # /
Ordre no : 004

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

Linked to Existing Order /
Lien vers ordre existant: 2018_724640_0007, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically the licensee must:
Ensure that residents #009, #016, #017, #018, #025, #034, #035 and any other resident are protected from abuse by anyone.

Grounds / Motifs :

(A1)
1. The licensee has failed to comply with compliance order #001 from inspection #2018_724640_007 issued on April 10, 2018, with a compliance due date of May 7, 2018.

The licensee was ordered to;

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

Specifically the licensee must ensure:
1) That residents #001, #002 and #003 and any other resident are protected from physical abuse by anyone.
2) That the identified staff are provided face to face instruction related to Abuse and Neglect of residents, reporting requirements when abuse or neglect is suspected and action the home will take when abuse or neglect of a resident has been identified.

The licensee failed to ensure that step 1 of compliance order #001 was completed. The licensee completed step 2 of compliance order #001.

The licensee failed to ensure that residents were protected from abuse by anyone.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Review of CI #0901-000014-17 submitted to the Ministry of Health and Long Term Care (MOHLTC) dated July 4, 2017, reported resident to resident abuse. The CI

report stated that on July 2, 2017, resident #015 touched and squeezed #017's right breast; on July 3, 2017, resident #015 sat beside #009, whispered in their ear and attempted to fondle their breast; and on July 4, 2017, resident #015 sat beside #018, whispered in their ear and pinched their nose. Review of CI #0901-000015-17 dated July 10, 2017, reported that resident #015 was witnessed touching resident #016's breast and was attempting to kiss the resident.

Review of resident #015's clinical records stated that the resident was an 83 year old man who was admitted to the home's dementia care unit on third floor on June 6, 2017, with several medical conditions including dementia. The resident had a cognitive performance scale (CPS) score of two, and was able to make decisions independently with some difficulty in new situations only. Resident #015's native language was Portugese but spoke and understood the English language and that there was no impairment to their communication skills. Documentation in resident #015 progress notes on June 29, 2017, 24 days after the resident was admitted, stated that the home began noticing the resident to have responsive behaviours.

Review of resident #015's progress notes stated four incidents where resident #015 inappropriately touched resident #034.
Review of the progress notes stated that that on June 30, 2017, resident #015 was observed with #034 sitting on a couch by the nursing station, holding hands and the two residents had kissed each other and that resident #015 had kissed #034 on their hand and forehead. Resident #034, who had Alzheimer's disease and dementia was deemed cognitively impaired to make their own decisions. The progress notes indicated the two residents were redirected by a staff member and the BSO RPN and the RN was notified regarding the incident. However, later that day at 2119 hrs, documentation showed that resident #015 and resident #034 was again sitting beside each other in the lounge area holding hands and but was not intervened by staff because there was no other physical contact observed.
On July 1, 2017, the staff observed two more incidents between resident #015 and resident #034. The progress notes stated that 1805 hrs, resident #015 was observed touching resident #034's shoulders and was overheard by staff telling resident #015 where their room was. A staff member then intervened and resident #015 became upset and asked why touching resident #034 was wrong and that resident #015 stated that they did not do anything wrong. Again at 2213 hrs, resident #015 was observed sitting very close with resident #034, the two residents holding hands and whispering and resident #015 was heard asking resident #034 if they could look down their nightgown and then began to fondle resident #015's breast. Staff

intervened and separated the two residents after the incident occurred.
On July 3, 2017, resident #015 was observed with resident #034 attempting to assist resident #034 on their lap. Staff intervened and redirected the resident after the incident had occurred. On July 5, 2017, resident #015 was observed caressing resident #034's hand and side while they sat on the sofa and yelled and swore at staff when they were told to stop touching resident #034.

There were two incidents of sexual abuse displayed by resident #015 towards resident #017. On July 1, 2017, resident #015 was witnessed by staff squeezing resident #017's right breast as the two resident were sitting on a couch in front of the third floor nursing station.The two resident were separately immediately. According to resident #017's clinical records the resident had dementia and was cognitively impaired to make their own decisions and was not able to given consent. On July 4, 2017, at 2100hrs, resident was sitting beside resident #17, and was observed touching the resident's chin. Staff intervened and told resident #015 that touching others was not appropriate. Resident #015 became upset and stated to the staff that they were not doing anything wrong. Resident #015 then began swearing in their language, and resident #017 was separated from resident #015. It was observed that after this incident resident #015 was still sitting in the lounge area beside resident #017.

There were two incidents of sexual abuse displayed by resident #015 towards resident #018. On July 2, 2017, at 2037 hrs, resident #015 was observed touching resident #018's buttocks, and later on and again touch #018 on their back and pinched their nose. Resident #018's clinical records indicated the resident was cognitively impaired and was unable to make their own decisions. Staff intervened after the incident had occurred.

There was one incident of resident to resident sexual abuse from resident #015 towards resident #009. On July 2, 2017, at 2142 hrs, resident #015 was observed sitting beside resident #009 who had dementia and was cognitively impaired, leaned and whispered to the resident, and attempted to fondle the resident's breast. Staff intervened after observing this interaction between resident #015 and resident #009 after the incident had occurred. Documentation showed resident #015 continued to "follow the ladies around the unit". The resident was heard asking the staff what they were doing wrong and that resident #015 told the staff that "everyone is my friend".

On July 8, 2017, staff observed three incidents of resident to resident sexual abuse from resident #015 towards resident #25, a resident who was cognitive impaired. Resident #015 walk over to resident #25, touched their hair and told them that they were a "good lady"; and later on that evening during the meal service, resident #015 walked over to resident #25 to fix their clothing protector and later during the evening, staff observed resident #015 sitting near resident #25 on the couch all and was staring at the resident. Resident #015 was redirected and was told by staff not to touch resident #025.

There were two incidents of resident to resident sexual abuse from resident #015 towards resident #035. On July 9, 2017, at 1859 hrs, staff observed two incidents of inappropriate touching displayed by resident #015 towards resident #035. Resident #035's clinical records indicated the resident was cognitively and physically impaired. Resident #015 was observed sitting on the sofa beside resident #035 with their shirt unbuttoned and was attempting to get the resident out of their chair and was telling the resident they loved them while touching their hair and their face. At 1907 hrs, staff observed resident #015 walked back to the other sofa near resident #035 and touched their elbow, shoulder and stroked both sides of their face. The progress notes indicated the resident was redirected to stop touching resident #035 after the incidents occurred. No further follow up was noted.

There was one incident of resident to resident sexual abuse from resident #015 towards resident #016.
On July 11, 2017, at 1913hrs, staff observed resident #015 touching resident #016's breast and was attempting to kiss them and began masturbating in the centre lounge. Resident #016 clinical records stated that the resident was cognitively impaired. Resident #015 then left the area and went to their room when they saw that the staff had seen what they were doing. The progress notes stated the DRSF spoke with resident #015 and explained to the resident that touching female residents was inappropriate and was considered sexual assault and that the police would be notified about what they had done. Resident #015 stated to the DRFS that resident #106 had wanted to be touched by them.

There were 17 incidents that occurred where resident #15 displayed responsive behaviours of a sexual nature towards female residents and that the interventions were ineffective and did not prevent the incidents from happening.

Interviews with RPNs #113, #107, and #138, they told the Long-Term Care Homes

(LTCH) Inspector that resident #015 had responsive behaviours of touching other female residents and that the interventions was to monitor and keep resident #015 away from the other residents by trying to make sure that resident #015 was not seated next to any female residents, and telling the resident that it was inappropriate to touch the female residents.

During an interview with the BSO RPN, stated that they were not the BSO Nurse during the time the abovementioned incidents but acknowledged that the incidents occurred. They stated that they were aware that resident #015 had displayed responsive behaviours that were inappropriate towards female residents and shared with the LTCH inspector that the resident was monitored using Dementia Observational System (DOS), was referred to the psychiatrist for further follow up, and was ordered medications. In addition to these interventions, staff monitored the resident when they were sitting near a female resident to ensure they do not touch them, and inform the resident when they begin to exhibit responsive behaviours that touching other residents is inappropriate.

The licensee failed to ensure that residents #009, #016, #017, #018, #025, #034, #035, were protected from sexual abuse from resident #015.

The severity of this issue was determined to be a level 2, minimal harm or potential for actual harm. The scope of the issue was a level 2, pattern, as seven of 10 residents inspected were impacted by the same resident who had repeated occurrences of the same practice. The home had a level 4 compliance history of ongoing non-compliance despite action taken by the Ministry that included:

- Compliance Order #001 issued December 29, 2017 with a compliance due date of January 31, 2018 (2017_482640_0025)
- Compliance Order #001 issued February 28, 2018, with a compliance due date of May 7, 2018 (2018_724640_007)
(640)

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

Nov 02, 2018(A1)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 005

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

Linked to Existing Order / Lien vers ordre existant: 2018_724640_0007, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee must comply with s. 53 (4) of O. Reg. 79/10.

Specifically the licensee must ensure;

That resident #015 and any other resident demonstrating responsive behaviours are assessed and/or reassessed related to those responsive behaviours and interventions revised and implemented based on those assessments.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #2018_724640_0007 issued on April 10, 2018, with a compliance due date of June 4, 2018.

The licensee was ordered to;

The licensee must be compliant with s. 53 (4) of O. Reg. 79/10.

Specifically the licensee must:
1) Ensure that direct care staff implement the strategies and interventions developed for resident #001's responsive behaviours.
2) Re-assess resident #020 regarding their responsive behaviours as per Compliance Order #001 from inspection #2017_482640_0018 served on November 17, 2017, and update the plan of care accordingly.

The licensee completed steps one and two from the order.

The licensee failed to comply with s. 53 (4) of O. Reg. 79/10.

The licensee failed to ensure that, for each resident demonstrating responsive behaviours actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions.

Review of CI report submitted to the Ministry of Health and Long Term Care (MOHLTC) reported resident to resident abuse. The CI report stated that on several identified dates in July 2018, resident #015 inappropriately touched resident #017.

Documentation in resident #015's progress notes after the resident was admitted, stated that the home began noticing the resident to have responsive behaviours of inappropriate action toward other residents.

On several identified dates in July 2017, resident #015 was witnessed by staff inappropriately touching several co-residents.

The progress notes stated the DRFS spoke with resident #015 and explained to the resident that touching other residents was inappropriate.

Review of resident #015's plan of care continued to have the same interventions of monitoring the resident's behaviours and intervening only after resident #015 had already touched a resident. There were numerous incidents that occurred where

resident #15 displayed responsive behaviours towards other residents and that the interventions were ineffective and did not prevent the incidents from happening.

During interviews with RPNs #113, #107, and #138, they told the Long-Term Care Homes (LTCH) Inspector that resident #015 had responsive behaviours and the interventions were to monitor and keep resident #015 away from other residents.

During an interview with the BSO RPN, they indicated that resident #015 had displayed responsive behaviours that were inappropriate towards other residents. They stated that the resident was monitored using Dementia Observational System (DOS) and was referred to special services for further follow up.

The licensee failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions. [s. 53. (4) (c)]

The severity of this issue was determine to be a level 2 as minimal harm or potential for actual harm. The scope of the issue was a level 2, pattern. The home had a compliance history of a level 4 that included:
- Compliance Order #001 issued November 17, 2017, under inspection #2017_482640_0018 with a CDD of December 28, 2017.
- Compliance Order #002 issued April 10, 2018, under inspection #2018_724640_0007 with a CDD of June 4, 2018 was re-issued as there was non-compliance found with the follow up inspection to O. Reg. 79/10, s. 53 (4) CO #001 issued under inspection #2017_482640_0018

(640)

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

Nov 02, 2018(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 18 day of October 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Service Area Office / Bureau régional de services : Central West