Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 25, 2016	2015_286547_0025	033518-15	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.4) GP Inc. as general partner of CVH (No.4) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Inc. CAMBRIDGE ON N3H 5L8

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

MANOIR MAROCHEL
949 MONTREAL ROAD OTTAWA ON K1K 0S6

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

LISA KLUKE (547), AMANDA NIXON (148), ANGELE ALBERT-RITCHIE (545), JESSICA LAPENSEE (133), MEGAN MACPHAIL (551), MELANIE SARRAZIN (592)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 14,15,16,17,18,21,22,23,30,31, 2015

The following critical incidents, complaints and follow-up to orders inspections were conducted concurrently during this Resident Quality Inspection: 019644-15, 022510-15, 024195-15, 024398-15, 027506-15, 029283-15, 030838-15 and 035082-15.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC),Regional Director Assistant (RDA), RAI Coordinator, Clinical Nurse, Dietary and Support Services Manager, Program Manager, an Activity Programmer, Maintenance Manager, Office Manager, Registered Dietitian (RD), Physiotherapist, Physiotherapy Assistant, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Workers, Housekeepers, Laundry attendants, Volunteers, Residents and Family Members.
In addition the inspection team, reviewed resident health care records, food production documents including planned menus, Family Council minutes, Resident Council minutes, Resident Information package, documents related to the home's investigations into critical incidents that were reported by the home to the Director, policies and procedures related to complaints, restraint use, odours, resident room/washroom cleaning, falls prevention, urinary catheterization, medication pass, medication reconciliation, narcotic and controlled drugs, resident abuse-staff to resident, resident abuse by persons other than staff, mandatory on-line training: Surge Learning education for prevention of abuse. The inspection team observed aspects of resident care and interactions with staff, along with medication administrations and meal services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Admission and Discharge
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
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #001	2015_346133_0040	133
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2015_225126_0025	592

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. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

The licensee has failed to ensure that supplies, equipment and devices such as functional pagers, are readily available at the home to meet the nursing and personal care needs of residents.

For the purposes of this report, pagers are used by nursing staff to enable the resident-staff communication and response system by directly notifying nursing staff when a call for assistance has been made by a resident.

On December 14, 2015 at 13:05pm, Inspector #592 observed the dome light outside of a resident's room illuminating on the South unit. After 7 minutes, the dome light was still illuminating and no staff were noted to be around. Inspector #592 noted PSW #130 in the hallway and upon asking her about the call bell in this resident's room, she told Inspector #592 that she was not in possession of her pager as it was broken. Inspector #592 interviewed RPN #129 who was at the nurses station and indicated that he does not carry any pagers but that he relied on the dome light outside of the resident rooms. RPN #129 stepped out of the nurse’s station and told Inspector #592 that there was no call light activated as there was no dome light illuminated. Inspector #592 noted that there was a wall mounted fan at the front of the dome light, therefore the activated dome light was impossible to be viewed. RPN #129 further indicated to Inspector #592 that he relied on the board in the nurses station as well and indicated to Inspector #592 the light on the call bell board. RPN #129 indicated to Inspector #592 that he would send someone to answer the call bell in this resident's room.

On December 14, 2015 at 11:56 am, Inspector #545 activated the call bell in a shared bedroom on the West unit which did result in the illumination of the dome light outside of the resident’s bedroom. PSW #103 arrived 5 minutes later and informed Inspector #545 that he saw the dome light outside the residents room, but did not hear it as he has no batteries in his pager today. He further informed Inspector #545 that he left his pager at the nursing station after breakfast today, expecting management to replace the batteries. Inspector #545 spoke with PSW #103 later on that same day upon activating another call bell on the West unit as PSW #103 arrived several minutes after and told Inspector #545 that he saw the dome light flashing but that he was not in possession of his pager as it was still not available to him; therefore he did not carry a pager during his day shift.

On December 14, 2015, at 14:50 pm, Inspector #547 activated two call bells in Resident rooms on the West unit which resulted in the illumination of the dome light outside of these resident bedrooms. After 5 minutes, Inspector #547 went to look for staff members and approached PSW #111 who informed Inspector #547 that she was working on the unit and that she was not in possession of her pager as it was broken. PSW #111 further indicated that her co-worker PSW #103 had lost his pager and that they are both assigned to group #4. PSW #111 indicated they know to look in the hallway to see dome lights lit. PSW #103 and #111 told Inspector #547 that at 14:00 pm, they sit at the end of the hallway at a desk to do their charting, and they are able to look up to see bell lights. It was noted that both staff members remained seated at this desk at the end of the hallway and confirmed with Inspector #547 that they did not notice the dome lights for these resident rooms. In an interview with evening PSW #112 who was distributing the beverages for residents on that same unit,she told Inspector #547 that she is not in possession of a pager until 15:00 pm, as she arrived at 14:00 pm to do snack pass and was not responsible for residents or to respond to call bells until 15:00 pm.

On December 14, 2015, at 15:45 hours, Inspector #545 activated a call bell in a shared bedroom on the West unit, which did result in the illumination of the dome light outside of the resident's bedroom. After 5 minutes, PSW #132 arrived in the room and Inspector #545 asked PSW #132 to show the display on the pager, the pager was blank and did not identified any room number. PSW #132 indicated that the pager's batteries were probably dead.

On December 15, 2015, at 14:05 pm, Inspector #545 activated a call bell in a shared bedroom on the West unit which did result in the illumination of the dome light outside of the resident's bedroom. PSW #125 arrived 6 minutes after and told Inspector #545 that he just saw the light flashing but that he was not in possession of his pager as it was broken and gave it back at the morning report to the RAI coordinator and that the pager had not been return to him.

On December 16, 2015 the Administrator informed Inspector #133 that 4 new pagers were ordered as a result of the last Ministry Of Health and Long-Term Care inspection conducted on October 1, 2015 for this same issue resulting in a voluntary plan of correction required by the home. The new pagers were picked up by the Office Manager on December 3rd, 2015 and the home was informed on December 11, 2015 by the outside vendor, that the new pagers could not be configured to the system due their company staffing issues and being unable to reconfigure the pager system for now. The Administrator informed Inspector #133 that the home plans to implement a contingency

plan in the meantime, involving the use of walkie talkies that were bought yesterday. The home is planning to start the distribution of the walkie talkies tomorrow as they will be fully charged, while waiting for the pager system to be configured. A note was left to all staff members by the DOC at the nurses' station with the instructions for the walkie talkies system.

On December 18, 2015, at 10:18 hours, Inspector #148 observed the communication system to be activated in a resident's room on the South wing. At 10:35 the communication system remained activated as staff had yet to respond. At this time Inspector #148 approached Resident #050, who had activated the call bell, and the resident indicated the need to go to the bathroom and that he/she is holding it as best as the resident can. Inspector #148 approached PSW #125, who had been in close proximity to this resident's room, providing care and assisting in the tub room during the Inspectors observations. The Inspector informed PSW #125 of the activated communication system and that Resident #050 had expressed a need to use the bathroom. PSW #125 indicated that the activated call from this resident room did not present on his pager as the batteries were low and needed to be charged, demonstrating that no calls were present on his pager.

The Administrator and the RAI coordinator confirmed with Inspector #592 that there should be a functional available pager for every PSW on the floor and that three of eight pagers were not available for use by nursing staff at the time of the inspection. These pagers are connected to the resident-staff communication and response system which directly notifies nursing staff when a call for assistance by the resident has been made. This presents a widespread issue in the home for residents care needs to be met when they cannot communicate with the nursing staff that care for them.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one Registered Nurse (RN), who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

A review of Manoir Marochel's RN Staffing Schedule for the period of September to December 31, 2015 was reviewed and indicated the following:

On three specified dates in October, 2015, the home did not have an RN to work in the home on the day shift
On another specified date in October, 2015, the home did not have an RN to work in the home on the evening shift

On a specified date in November, 2015, the home did not have an RN to work in the home on the evening shift
On another specified date in November, 2015, the home did not have an RN to work in the home on the night shift
On another specified date in November, 2015, the home did not have an RN to work in the home in the day shift
On three specified dates in December, 2015, the home did not have an RN to work in the home on these day shifts
On another specified date in December, 2015, the home did not have an RN to work in the home on the evening shift

Manoir Marochel is a 64 bed Long-Term Care Home.

Ontario Regulation 79/10 section 45 (2) indicates that "emergency" means an unforeseen situation of a serious nature that prevents a Registered Nurse from getting to the Long-Term care home.

Each of the eleven shifts when there was no RN working in the home were reviewed with the Office Manager, who is in charge of scheduling, and none were due to an emergency. The Office Manager indicated that she attempts to replace an RN shift with an RN but when this is not possible, the RN shift is covered by a Registered Practical Nurse (RPN). [s. 8. (3)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for Resident #052 sets out the planned oral care, the goals the oral care is intended to achieve and clear direction to staff and others who provide direct oral care to the resident. The written plan of care for Resident #052 also failed to set out clear direction to staff and others who provide direct nail care to the resident.

During an interview with the Resident #052's POA, he/she stated to Inspector #551 to have been recently contacted by a nurse and told that the resident's finger nails had to

be cut short for safety and hygiene. The POA stated that he/she had not been previously told of this rule and wanted the resident to have long, clean finger nails that could be maintained by filing. The POA stated that it was his/her preference that a member of the family for Resident #052 completed the resident's nail care rather than staff.

RPN #107 stated to Inspector #551 that as the resident's family wanted the finger nails kept long that the family was responsible for her nail care.

Inspector #551 reviewed the current plan of care for Resident #052 and noted under Personal Hygiene it stated Special nail care by foot nurse specialist. The care plan did not address Resident's #052's finger nail care needs.

The DOC stated that the care plan did not provide clear direction to staff with regards to Resident #052's nail care as the resident did not require specialized nail care and the family had not consented for this. The DOC further stated that the home's staff were responsible for cutting the resident's nails. The DOC stated that she had met with the resident's family earlier that day and was working on a plan to address the resident's nail care needs.

During an interview with the resident's family, he/she stated to Inspector #551 that on several occasions, he/she found the resident in the dining room at supper time without his/her dentures inserted.

PSW #138 stated that Resident #052 requires extensive assistance for care. He stated that in the morning, he washed the resident's dentures and the resident inserted them.

Resident #052's care plan was reviewed by Inspector #551 and there is no mention of oral status or oral care needs.

The DOC reviewed the resident's care plan and indicated that it did not address Resident #052's oral care needs.(regarding log #024195-15) [s. 6. (1)]

2. The licensee has failed to ensure that the plan of care for Resident #018 was based on an assessment of the resident and the resident's needs and preferences regarding bathing and dressing.

Resident #018 has several medical conditions and according to the most recent assessment, the resident resisted care several times per week and this behaviour was

not easily altered.

In a review of the Resident's plan of care it was indicated Resident #018 required extensive assistance of one staff for bathing. It was also documented that the resident enjoyed both a shower or a bath and to allow the resident to choose. Gentle persuasive approach was also required and to allow the resident to participate in the task. Under the section Eating, it was documented that the resident stayed in bed in the morning, and often skipped breakfast and lunch.

The Bath Schedule for this resident indicated that the resident was bathed once a week in the evening and once a week in the morning. The daily flow sheets indicated that the resident received four out of eight baths in a specified month in 2015.

During an interview with PSW #106, she indicated to Inspector #545 that Resident #018 did not want to get up in the morning. Resident #018 use to receive both baths only in the evenings however the resident's family took the resident out on of those evenings and the bath time was required to be changed. The resident's bath was changed to a morning. The PSW indicated that the resident preferred to stay in bed in the morning and often refused to get out of bed.

RPN #107 indicated that the evening bath was changed a few months ago to accommodate the resident's outing and that it was the home's expectation that PSW's alert the registered staff when the resident refused a bath in order to notify the family. RPN #107 was aware that the resident did not get up in the morning.

The Clinical Nurse indicated that the resident's needs and preferences had not been considered in planning the bath schedule, as it is well known that this resident doesn't get up in the morning.

Resident #018 shared a bedroom with another resident who according to staff receives visits from her family regularly. According to the most recent assessment, Resident #018 required limited assistance of one person for dressing.

On December 15, 2015 Inspector #545 observed Resident #018 sleeping in bed with a night shirt and underwear on. The resident had no pants and a blanket was observed at the end of the bed. The privacy curtain was not drawn, therefore exposing the resident’s legs.

On December 17, 2015 Inspector #545 observed Resident #018 sleeping in bed with his/her underwear was pulled down, exposing the resident's buttocks. A blanket was observed at the end of the bed. The privacy curtain was not fully drawn, therefore exposing the resident's legs and buttock.

On December 18, 2015 Inspector #545 observed Resident #018 sleeping in bed with no underwear on. The resident's underwear was on the dresser. The curtain was not drawn, exposing the resident's legs and buttock.

In a review of the most recent plan of care, it was indicated that the resident required limited assistance of one staff to dress, to do zippers and buttons. There was no information related to the resident's needs and preferences regarding dressing habits when sleeping and how to manage privacy in a shared bedroom.

During an interview with PSW #106, she indicated that the resident always removed his/her underwear; she thought that the resident probably took them off when going to the washroom and did not put them back on and added that she sometimes observed the resident walking back from the bathroom with the underwear halfway up.

RPN #107 indicated to the Inspector that she was aware that the resident slept most of the day and got up just before supper time. She further indicated that the resident often slept with no underwear on, added that she did not know why the resident undressed to sleep and that she was concerned as the resident shared a bedroom with another resident who had visitors regularly. The RPN further indicated that often when she administered the medications before breakfast, the resident was in bed, undressed and she would have to draw the privacy curtain herself as the resident was found undressed.

During an interview with the Clinical Nurse, she indicated to Inspector #545 that she was aware that the resident refused to get up and go for breakfast, but was not aware the resident undressed. She indicated that it was the expectation of the home to address the resident's needs and preferences and that she would update the plan of care. [s. 6. (2)]

3. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible; strategies are developed and implemented to respond to these behaviours, where possible; and 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.

According to the most recent assessment, Resident #011 was incontinent of bladder two or more times a week but not daily and the resident wore pads or briefs. It was also indicated, in the assessment, that the resident was resistive to care which was not easy to alter and had no socially inappropriate behaviour.

In an interview Resident#011 indicated to Inspector #545 that he/she chose to urinate in an inappropriate location and that it was easier and has always done this in the past. The resident also indicated that he/she found it difficult to use the toilet and was finding that urine always hit the floor and wall. The resident then indicated that he/she sometimes dribbled urine on the floor when voiding and would throw paper towel on the floor to absorb the urine. Resident #011 showed Inspector#545 that he/she wore special pull up style briefs.

In a review of the most recent plan of care, information regarding these behaviours such as the use of this inappropriate location to urinate instead of the toilet was not found.

During interviews with PSWs #121, #133, #138, RPN #107, the RAI Coordinator, Housekeeping Staff #132, the Support Services Manager and the Maintenance Manager, all indicated that they were aware Resident #011 used an inappropriate location to urinate. Staff indicated that the resident's behaviours were related to wanting to save water and therefore did not want to urinate in the toilet.

PSW #102 identified himself as the Behavioural Support Ontario (BSO) champion; he indicated to the Inspector that he was involved with Resident #011 as the resident had several socially inappropriate behaviours such as refusing bath, change clothing including continence product and hoarding newspapers. He indicated that the geriatric outreach team was following the resident regularly, assisting with developing strategies to manage behaviours. When asked if he was aware that the resident used an inappropriate location to urinate, he indicated that he was aware. PSW #102 indicated that the resident had control of bladder but was not motivated to get up and use the bathroom. He further indicated and the brief was often wet because the resident was unsteady on his feet and was probably having difficulty pulling down his/her pants and brief and getting it damp from dribbling. The PSW indicated he had access to the plan of care, but had not reviewed it recently and indicated that he did not believe there was any information regarding the resident's behaviours related to choice location to void.

During an interview with the RAI Coordinator, he indicated he was responsible for the

assessment and care plan. He indicated that he was aware of the resident's inappropriate behaviour regarding location of voiding. He indicated that the behavioural triggers for the resident were not identified, that strategies were not developed and implemented to respond to this behaviour; and that actions had not been taken to respond to the toileting needs of this resident, including assessments, reassessments and interventions and that the resident's responses to interventions were not documented.

The DOC indicated that she was not aware of the resident's behaviour and that it was the home's expectation that the staff identified behaviour triggers, develop and implement strategies to respond to this behaviour and take action to respond to the toileting needs of Resident #011, including assessments, reassessments and interventions and that the resident's responses to interventions would be documented.

4. Regarding Resident #011's needs and preferences related to location of voiding.

The RAI Coordinator indicated to Inspector #545 he was responsible for the assessment and updating the care plan and that he was aware of the resident's use of an inappropriate location to urinate and that the Resident's voiding needs and preferences had also not been assessed. [s. 6. (2)]

5. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the bed mobility assessment of Resident #011 so that their assessments are integrated, consistent with and complement each other.

Resident #011 was admitted with several medical conditions and according to the most recent assessment, the resident had an unsteady gait and was independent for bed mobility.

During an observation on December 14, 2015, Inspector #545 observed Resident #011 in a single bed with a regular mattress and box spring on a frame with 4 wheels. There was no bed rails and no ability to raise or lower the bed. The inspector observed the resident rise from lying to sitting position on his own with some difficulty. On December 22, 2015 the bed had been moved and the inspector observed that the 4 wheels under the bed frame did not have a locking mechanism.

Inspector #545 reviewed Resident #011's health care records and noted a physician's prescription completed on a specified date in January, 2015 indicating that one bed rail

should be up for comfort and reassurance. The Daily Flow sheets completed by the PSWs working with this resident indicated that one bed rail was up daily on all shifts for the entire month of December 2015. The most recent plan of care indicated that Resident #011 was at high risk for falls and the bed should be in low position.

PSW #138 indicated to Inspector #545 during an interview that the resident did not have a hospital bed, therefore there was no ability to lower the bed or to raise one bed rail as none were available. He was unable to explain why PSWs including himself, documented daily use of one bed rail.

The RAI Coordinator indicated to Inspector #545 that he was responsible for updating Resident #011's plan of care, and upon entering Resident #011's room, he indicated that he had not been aware that the resident had his/her own personal bed. The RAI Coordinator further indicated that the resident should have a hospital bed to provide the resident with an ability to lower the bed, as well as a bed rail for comfort and reassurance, as prescribed by the physician. The RAI Coordinator indicated that he would be collaborating with the team to ensure the bed mobility assessment was consistent with all staff involved in the care of Resident #011. [s. 6. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care was based on an assessment of Resident's #011, #018 and #052 needs and preferences, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents.

Manoir Marochel is a two level home, including the main floor where resident bedrooms are located and where residents primarily conduct activities. The basement level includes a private dining space, Chapel, staff area and utilities. The basement is accessible to residents by the unsecured elevator.

On December 16, 2015, Inspector #148 took an initial tour of the home's basement. The door leading to the Staff Room, which includes staff washrooms, lockers and kitchen area, was not equipped with a lock and found to be accessible to residents. An interview with the home's Program Manager and DOC, confirmed that the Staff Room is not a resident area. The home's DOC indicated that a lock would need to be installed on this door. [s. 9. (1) 2.]

2. On December 14, 2015 at 09:15, Inspector #592 also took an initial tour of the home and noted an open the door titled "Soiled Utility" and observed inside this room, batteries and chargers on the wall and no call bell system. A key was noted to be attached to the upper corner of the door however no staff were noted in this area. PSW #118 indicated to Inspector #592 during an interview that the "Soiled Utility" door was to be kept locked at all times as it was not a residential area and went to lock the door.

At 9:20 during this same tour, Inspector #592 noted she was able to open the door titled "Resident Storage" containing an oxygen tank, continence products, suction equipment, a treatment cart not locked with dressings in it and with various nursing supplies. No staff were noted in the area either or any call bell system for residents. Housekeeping staff #119 indicated to Inspector #592 that the "Resident Storage" was to be kept locked at all times and was not to be accessed by the residents. Housekeeping staff #119 attempted to close the door but was unable to lock the door as the latching mechanism was not functioning.

On December 17, 2015, Inspector #592 had a discussion with the home's Clinical Nurse and the DOC regarding the closing and locking of doors leading to non-residential areas. They both confirmed that all doors leading to non-residential areas in the home are to be closed and locked when not in use by staff. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, to be implemented voluntarily.

WN #5: 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 has failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

For the purpose of this report, the communication and response system is referred to as a call bell system.

On December 14, 2015 while taking a tour of the home, Inspector #592 noted a large sitting area in the front lobby between the West wing and South wing hallways. This sitting area is used daily by residents in the home. No call bell system was observed in this sitting area or in any adjacent hallways for resident-staff communication.

On December 21, 2015 during an interview with the Maintenance Manager, he confirmed with Inspector #592 that the front lobby is a place where residents gathered and was accessible to all residents. He further confirmed that the front lobby was never equipped with a communication and response system for residents. [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 to ensure that there is a resident-staff communication and response system that is available and accessible by residents in the front lobby, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The inspection team observed items found in semi-private rooms including unlabelled toothbrushes, unlabelled denture cups, unlabelled used deodorants, unlabelled hair combs with visible hair. Items were found on the wall mounted shelves and counter tops of shared bathrooms.

Inspector #592 observed unlabelled hairbrushes with visible hair and used deodorants in the bath tubroom on the West Unit.

On December 16, 2015, in an interview with PSW # 100, he indicated to Inspector #592 that the labelling of personal items were not required when a resident was residing in a private room and that was only required in a shared rooms/bathrooms.

On December 17, 2015, in an interview with PSW #108, she told Inspector #592 that resident's personal items are identified with a marker by registered nursing staff. PSWs will ask the nurse to identify the items and return them labelled.

On December 17, 2015, in an interview with RPN #101, he told Inspector #592 that the home has a process for the labelling of residents personal items which is for the Registered staff members to label all personal items upon resident's admission. He further indicated that PSWs does not have access to the label printer equipment but will ask Registered staff when they need new resident's items in order for them to label the new item and give it back to PSW. RPN #101 further indicated that sometimes the personal items are labelled with a dark marker or a sticker depending of the item surface.

On December 17, 2015, in an interview with the DOC, she told Inspector #592 that all the resident's personal items are to be labelled. She further indicated that the labelling of personal items occurs upon any resident admission and upon any new acquired personal items. The DOC indicated to Inspector #592 that she was told by the previous DOC that the home knew that the resident's personal items were not labelled as expected by the home. [s. 37. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home has his or her personal items labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident exhibiting 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.

Resident #036 was identified with a pressure ulcer.

A review of Resident #036's health care records indicated that Resident #036 was admitted with a diagnosis of pressure ulcer on a specified date in July 2015.

As per the current physician orders, Resident #036 was to have dressings to this pressure ulcer changed every three days and as needed. The wound is to be cleaned and covered on the wound base as prescribed and to cover the wound with foam.

On December 23, 2015, the home's skin coordinator indicated to Inspector #592 that Resident #036 had dressings changed every 3 days and as needed since admission. The skin coordinator further indicated that Registered staff were to re-assess Resident #036's skin condition with every dressing change by performing a weekly wound care record in their electronic record.

Upon review of the weekly wound assessment records from July 2015 to December 2015 it was noted that there was no documented record of any skin assessment being completed on seven specified dates in this period.

On December 23, 2015, the skin coordinator indicated to Inspector #592 that he was not aware that the Registered Nursing staff did not complete weekly skin assessment for Resident #036. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident exhibiting altered skin integrity, are reassessed at least weekly by a member of the registered nursing staff if clinically indicated, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

The home's Family Council was re-established at a meeting on May 26, 2015. The monthly minutes of the meetings were reviewed by Inspector #545. Concerns and suggestions were documented in the minutes of the following meetings:

July 28, 2015
-family members requesting to be notified when resident's care needs change, and more frequent access to Management beyond once per year
-family members requesting knowledge of roles of staff and activities to better understand what the staff do
-requesting that emotional care be provided as well as physical care
-family members requesting to be notified when specialist care takes place, for example dentistry

August 25, 2015
-family members concern that food is being served cold to the residents, would like more fresh fruits, would like to understand dining room process
-suggestion to do a spaghetti night this coming fall and to plant flowers and provide garden care
-suggestion to setup a computer for the residents to allow them to communicate via email or Skype with their family members

September 29, 2015
-food is still being served cold

-desserts are too sweet, wondering if ice cream could be served
-two members cleaned a wasp nest on the grounds, concern re: someone being stung, would like to establish a special council meeting to look at improving the home's grounds
-ongoing problems with laundry
-concern regarding residents at risk for urinary tract infections

October 2015
-ice not available, wondering if there is a problem with the ice machine
-milk and juices are not served cold enough
-residents' bathrooms and bedrooms are unclean
-latex gloves are found on the floors
-food is still not served warm enough, suggestion to provide a better selection of food
-residents are hurried when fed by staff
-laundry: missing clothing, labels coming off
-suggestion to provide a location for family members to visit with the residents, including access to a kettle, a microwave and snacks

During an interview with the President of the Family Council, he indicated that the home did not respond in writing to concerns or recommendations made by the Council. He indicated that the minutes were taken by him and sent to the Assistant following the meetings.

The Assistant to the Family Council indicated to Inspector #545 that the President provided the minutes to the meetings and that she posted the minutes on the bulletin boards of both activity rooms in the home.

The Administrator indicated to the Inspector that he was the representative of the licensee. He indicated that he had not read the minutes of the Family Council and that he believed that the Family Council had not been formerly established yet. He indicated that he was not aware that the minutes were posted in the activity rooms of the home. [s. 60. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a written response to Family Council within 10 days of receiving advice related to concerns or recommendations, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to implement as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the home's procedures for addressing incidents of lingering offensive odours.

The home's Extendicare Odours, HL 05-03-08, dated September 2015, along with Appendix I - Odour control investigation tool (HKLD 05-03-03), was reviewed by Inspectors #545 and #547. The Procedures section of the Policy stated that the home will investigate all complaints and reports of unacceptable lingering odour as soon as possible. The objective of this review is to identify the source of the odour and correct the issue.

Item 1 of the policy stated that the Support Services Manager/Designate will identify the source of the odour; it is recommended using Appendix 1 - Odour Control Investigation Tool as a guide.
Item 4 of the policy stated that the Support Services Manager/Designate will investigate the area again in 1 to 2 weeks if needed to see if there is a change, and if the odour persists, repeat investigation.

On December 14,2015 at 1600, December 21, 2015 at 1030 and again at 1700 this same day, Inspector #545 observed a lingering offensive odour in Resident #011's bed room. An air freshener was observed at the entrance of the resident's room at the top of the door frame. In the resident's private bathroom, an air freshener was observed on the wall above the sink and a can of disinfectant spray was observed on the top shelf of the cupboard. Brown paper towel was observed on the floor under the bathroom sink with a strong odour of urine.

During an interview with PSW #121 she indicated that a lingering offensive odour was always observed by staff in the resident's room and especially in the bathroom. She further indicated that Resident #011 used an inappropriate location to urinate and had been doing this for a long time. PSW #121 further indicated no strategies were found to convince the resident to use the toilet to urinate and prevent these offensive odours.

Housekeeping Staff #132 indicated to Inspector#545 that she reported the lingering offensive odour in Resident #011's room on many occasion, but because this resident continued to use this inappropriate location to urinate versus the toilet, there was no other solutions at this time.

The Support Services Manager indicated to Inspector #545 that Resident #011's floors in the bedroom and bathroom were stripped, scrubbed and buffed on specified dates in November and December 2015. The Support Services Manager indicated she audited the resident's room and bathroom and found that the sink and toilet continued to have urine odour. She further indicated that she did not use Appendix 1 - Odour Control Investigation Tool as a guide, or investigate the area again 1 to 2 weeks when the odour persisted, added that other than cleaning the sink and toilet daily with Urine Contamination Treatment, there was no other housekeeping solutions to manage the lingering offensive odour in Resident #011's bathroom and bedroom. [s. 87. (2) (d)]

2. On December 15,16,17,21,22, 2015 Inspector #547 noted a lingering offensive odour of urine in Resident #028's shared bedroom. The residents mattress was noted to be the source of the lingering odour.

On December 22, 2015 Inspector #547 interviewed the Support Services Manager, who indicated after reviewing the South wing-Odour Housekeeping Log book, that there was no entries regarding any odours in Resident #028's room. This communication book is required to be used by all staff to communicate odour issues in the home and the Support Services Manager reviews these communication books daily. The Support

Services Manager further indicated that after lifting the sheets from the bed that was made that morning, that the resident's mattress also was noted to have lingering offensive odour. PSW staff are responsible to change the residents bed linens and to disinfect mattresses prior to re-applying fresh linens.

The Supportive Services Manager indicated that the home has a urine contamination treatment neutralizer to use for lingering offensive urine odours, however there was none available in the South wing housekeeping room and that these bottles were re-ordered that day.

Inspector #547 interviewed RPN #107, PSW #121 and #146 in the West wing of the home, who indicated that mattresses are no longer cleaned when linen is changed on the beds as they no longer have access to the accel wipes they previously used as they are no longer available. Housekeeping aide #132 indicated that the home does have the urine neutralizer spray, but that it is not used on mattresses that she is aware of. Housekeeping aide #120 who is part time in the home working in the South wing, indicated to Inspector #547 that the home does not have any specialized cleaning product for lingering offensive urine odours. PSW #125 responsible for Resident #028 indicated that he uses the cleaning product used for the tubs and showers, as they no longer have the accel wipes. No PSW indicated they were aware of the urine contamination treatment neutralizer to manage offensive lingering odours. [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the implementation of homes procedures developed as part of the organized program of housekeeping for addressing incidents of lingering offensive odours by all staff in the home, to be implemented voluntarily.

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

Findings/Faits saillants :

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

On a specified date in November, 2015 Resident #032 reported to the Program Manager of the home that a staff member had threatened him/her. Resident #032 indicated that PSW #141 entered the residents shared bedroom and was found sitting watching the other resident's television and stated to Resident #032 to "forget what you see or else" and repeated this three times to the resident.

O'Reg 79/10, s.2(1) identifies verbal abuse as:
a) Any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well being, dignity or self-worth, that is made by anyone other than a resident.

On December 30, 2015 Inspector #547 interviewed Extendicare's Regional Director Assistant (RDA), the acting Director of Care at the time of the reported incident of alleged and suspected verbal abuse of Resident #032 by Staff #141 on this specified date in November, 2015. The RDA indicated that Resident #032 is cognitively alert and oriented and investigated this complaint. The RDA indicated that she did not call any police force regarding this alleged, suspected staff to resident verbal abuse as there was no injury to Resident #032. [s. 98.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the appropriate police force is immediately notified of any alleged, suspected, or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #11: 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 are administered to residents in accordance with the directions for use specified by the prescriber.

Resident #011 was admitted to the hospital on a specified date in February, 2015 during a respiratory outbreak in the home. Inspector #545 reviewed the medication administration records for Resident #011 and noted that upon return from hospital that the resident was ordered inhalation medication.

There was no evidence to demonstrate that this inhalation medication was administered to Resident #011 upon return from hospital.

Resident #018 was also admitted to the hospital during a Respiratory Outbreak in the home on a specified date in January, 2015 and returned 11 days later whereby the New Admit/Re-Admit Medication Reconciliation MAR and Drug Record indicated a specified medication for prophylactic reasons to be provided to the resident daily for a specified period of time.

The Medication Administration Record for the month of February 2015 was reviewed by Inspector #545 and noted transcription errors for this prophylactic medication entered for this resident. Resident #018 was administered this medication only once as ordered by the physician during this specified period.

During interviews with the Director of Care and the Nurse Consultant, they indicated that the medication reconciliation procedure had not been followed when Residents #011 and #018 returned from hospital in February 2015 and that the medications were not administered to these residents as prescribed. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to Resident #011 and #018 in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply 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 to be complied with, in that the home failed to ensure compliance with the following policies:

Complaints Policy #09-04-06, dated June 2010:

In accordance with O. Reg. 79/10, s. 100, every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101.

The Administrator indicated he was responsible for the home's complaints and provided

Inspector #545 with the home's current Complaints Policy, Number 09-04-06, dated June 2010 and noted on page 3 of 9, item 2-c stated:

-when a verbal complaint was received, the following will occur, if the verbal complaint can be resolved within 24 hours, the person receiving the complaint or the department manager will verbally respond to the person making the complaint the outcome/resolution.

On a specified date in December 2015 Resident #004 indicated to Inspector #545 that he/she had observed a PSW leaving Resident #053's bedroom with soiled clothing in her hands while leaving Resident #053 "bare legged" in bed with the resident's door open on a specified date in December 2015. Resident #004 was upset that the PSW did not provide Resident #053 privacy. Resident #004 indicated that he/she reported this complaint to the DOC a few days later, but could not recall the exact date and had not heard back from anyone.

During an interview with the DOC she indicated to Inspector #545 that she had received a verbal complaint from Resident #004 five days after the incident occurred regarding lack of privacy provided to a resident during care provision. She indicated that she immediately investigated and action was taken. When asked if she had responded to the complainant to share the outcome and resolution, she indicated that she did not know that was required.

The Administrator indicated during an interview with Inspector #545 that the DOC was new to the position and that she was not aware of the process. He indicated that a response to Resident #004 had not been done when the investigation of a verbal complaint was completed within 24 hours, as per the home's policy. [s. 8. (1)]

2. Medication Pass Policy #11-03, dated September 2010 and Narcotics and Controlled Drugs Policy #11-20 last revised on December 2011:

In accordance with O. Reg. 79/10, s. 114(2) every licensee of a long-term care home shall ensure that the written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The DOC provided Inspector #547 the home's current policy and procedure regarding Medication Pass #11-03 dated September 2010 which stated on page 1 of 2:

Registered Staff are not to pre-pour medications for residents; the rule of check one, pour one, sign for one is to be followed and practised.

On December 16, 2015 Inspector #547 observed the Resident #004's a medication inside a medication dispensing cup inside the resident's drawer. RPN #101 was conducting the medication pass for the 12:00 medications for residents. RPN #101 indicated that he had poured this controlled drug earlier while in the central lounge of the home. RPN #101 indicated that he had unlocked the double locked controlled drugs box to pour another resident's medications in order to save time he also poured Resident #004's controlled substance tablet and stored it in the resident's medication drawer inside a medication dispense cup. RPN #101 indicated that this is not the practise of the home.

On December 16, 2015 the DOC indicated to Inspector #547 that the home does not accept any pre-pouring of medication as per the home's policy and that this controlled drug should have been kept double locked in the narcotic box until it is poured for administration to the specified resident. [s. 8. (1) (b)]

3. Cleaning routine for resident room and washroom (sample), Policy number HL-05-03-02 A1, updated September 2015:

In accordance with O. Reg. 79/10, s. 87 (2)(a)(i), as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for, cleaning of the home, including, resident bedrooms, including floors.

The home's Cleaning routine for resident room and washroom (sample), policy number HL-05-03-02 A1, updated September 2015, was reviewed by Inspector #545 and noted on page 1 of 3 regarding Floor Maintenance stated:

3. Wet mop (full wash or spot clean) resident room area and full wash of bathroom. This is the final task to be completed prior to leaving area.
4. Place "Caution wet floor" sign upon exiting the room. Remember to check floor area and remove wet floor sign when completely dry.

On December 17, 2015 Inspector #545 and RPN #107 entered Resident #018's shared bedroom and Inspector #545's shoes slipped on something wet on the floor while

approaching the resident's bed. Resident #018 was seated on the side of the bed. Inspector #545 noted the room's floor was wet as it was recently washed however there was no "caution wet floor" sign in the room or at the Resident's door. At the entrance of the shared bedroom, a 4-star logo was observed by Inspector #545 posted by Resident #018's name. RPN #107 indicated to Inspector #545 that the logo was there to alert staff that this Resident was at high risk for falls.

RPN #107 indicated to Inspector #545 that Resident #018 was independent with ambulation and always slept in the afternoon therefore housekeeping staff wash the floors when the resident is in the dining room. RPN #107 further indicated that a "caution wet floor" sign should have been placed in the room to alert anyone entering the room that the floor was wet.

Housekeeping staff #120 indicated to Inspector #545 that the housekeeper that was responsible for this Wing had already left and that housekeeping staff usually mopped residents' floors when they were away for meals or when they were asleep. Housekeeping staff #120 indicated if a resident was sleeping, he would ask a nursing staff member if it was OK to mop the floor as wet floors usually dry within 6 minutes, but the "caution wet floor" sign was always put up.

During an interview with Housekeeping Staff #132, she indicated that she usually mopped Resident #018's floors in the morning. She indicated that it was her practise to put a "caution wet floor" sign after washing the floor but must have forgotten on December 17, 2015 in the afternoon when mopped the floor in that resident's room. She indicated she was aware that the resident was at risk for falls, that the resident often forgot to use his/her walker when getting up.

The Support Services Manager indicated to Inspector #545 that it was the expectation of all housekeeping staff to ensure to place a "caution wet floor" sign each time they washed a floor in resident's room & bathroom, as per the home's policy. [s. 8. (1) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall.

On December 14, 2015, Inspector #148 conducted a tour of the South wing shower and tub room. It was observed that the resident shower used for the residents of this wing, was equipped with one grab bar on the adjacent wall of the faucet. On the wall of the faucet, the shower head is attached to a vertical pole to allow the shower head to move up and down. The pole was found to move when any weight was placed on the pole; the pole is not a grab bar. There was no grab bar located on the same wall as the faucet.

On December 16, 2015, the Inspector observed the West wing resident shower to also have one grab bar on the adjacent wall and no grab bar on the same wall as the faucet. Later on the same day, the Inspector observed the West wing shower room with the home's DOC, who confirmed that there was only one grab bar available for use on the adjacent wall and that there was no grab bar on the wall of the faucet. [s. 14.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During the course of the inspection, it was noted that twenty eight out of forty residents observed during stage one of the Resident Quality Inspection had one or two bed rails used for the residents bed systems. Of these twenty eight beds, five mattress were noted to be too small for the bed frame, with gaps at the top or bottom of the beds between the mattresses and the head boards. Bed rails were also noted to be loose fitting along the sides of residents mattresses. Marochel Manor is a sixty four bed home.

Inspector #547 interviewed the Maintenance Manager on December 21, 2015 who indicated that approximately a year and a half ago, Cardinal Health came to the home to perform bed entrapment zone assessments for all the residents beds. The Maintenance Manager indicated that after evaluating two bed, the assessor indicated that if all beds were of this age, that they would all fail, and that there was no point to continue this assessment process. Cardinal Health did not leave any report of this assessment. The Maintenance Manager indicated that the home has since changed twenty one beds to new bed systems and mattresses. Of these new Twenty one new beds, none were verified for bed entrapment zone assessments to date as it was assumed that since they were new, that they would automatically pass the bed entrapment zone assessment. Forty one beds remain waiting for upgrade as per the Maintenance Manager as two residents have brought their own beds in the home. The Maintenance Manager further indicated that he was not aware of any evidence based practise, or what zones of entrapment to evaluate when bed rails are used.

As per a memo to LTC Homes in August 2012 by the acting Director, the Health Canada guidance document was provided as a link to all homes, and they were expected to use the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" document as best practise document. [s. 15. (1) (a)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In bedroom #138, on December 17th, 2015, at 3pm, Inspector #133 observed that the resident-staff communication and response system (the system) activation cord at the bedside was in poor repair. On the cord, before the end knob that houses the system activation button, the two internal coated wires were exposed. The last 2 – 3 inches of the outer protective casing of the cord was missing. The exposed wires were tied in a knot and there was a metal clip in place on the wires, used to affix the cord to the resident's pillow. The inspector pressed the system activation button and there was no call for assistance. The dome light outside of the bedroom did not illuminate and the panel at the nurses' station did not register a call. The inspector informed the RAI coordinator and he had the cord replaced.

In bedroom #142, on December 17th, 2015, at 3:10pm, Inspector #133 observed that the system activation cord at the bedside was in poor repair. On the cord, before the end knob that houses the system activation button, the two internal coated wires were exposed. The last 2 – 3 inches of the outer protective casing of the cord was missing. There was a metal clip in place on the wires, used to affix the cord to the resident's bed sheet. The inspector pressed the system activation button and there was a call for assistance. The inspector informed the RAI coordinator of the condition of the system activation cord and he had the cord replaced.

In bedroom #139, on December 17th, 2015, at 3:30pm, Inspector #133 observed that the system activation cord at the bedside was in poor repair. On the cord, before the end knob that houses the system activation button, the two internal coated wires were exposed. The last 2 – 3 inches of the outer protective casing of the cord was missing. The inspector pressed the system activation button and there was a call for assistance. On December 18th, 2015, the inspector returned to bedroom #139 with the Director of Care to observe the system activation cord at the bedside and it was noted that the cord had been replaced. It was determined that the home's Maintenance Manager had replaced the cord following an audit that morning. [s. 15. (2)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that at a minimum, the policy to promote zero tolerance of abuse and neglect of residents, clearly set out what constitutes abuse and neglect and contains an explanation of the duty under section 24 to make mandatory reports.

Upon the request of Inspector #148, two policies, both #OPER-02-02-04 and dated November 2013, were identified by the home's DOC as the home's policy to promote zero tolerance of abuse and neglect of residents. One policy was titled Resident Abuse – Staff to Resident and the second was titled Resident Abuse by Persons Other than Staff.

A review of both policies indicates elements of reporting to the Ministry of Health and Long Term Care (i.e Director), including mandatory reporting of suspected abuse or neglect of residents. The policies, however, do not include the duty to report as it relates to improper/incompetent care, unlawful conduct and the misuse/misappropriation of resident's money or funding.

In addition, upon review of the policy it was determined that the definitions of emotional, physical and verbal abuse and neglect were not consistent with the definitions of O.Regulation 79/10, s.2(1) and s.5. The definition of emotional abuse did not include: shunning, ignoring, infantilization or lack of acknowledgement. The definition of verbal abuse did not include: verbal communication of a belittling/degrading nature which diminishes a resident's sense of well-being dignity or self-worth made by anyone other than a resident or made by a resident that understands and appreciates its consequences. The definition of physical abuse did not include the administration of a medication for an inappropriate purpose. The definition of neglect indicates "immediate jeopardy", whereas the LTCHA, 2007, does not indicate jeopardy need be immediate to be neglect. The definition of neglect within the home's policy is further limited by indicating that neglect is a failure to provide treatment, care, services, assistance which is reasonably expected in the relationship.

The home's policy to promote zero tolerance of abuse and neglect of residents, does not provide for a clear explanation of the duty under section 24 of the Act or set out what constitutes abuse as indicated by the LTCHA, 2007. [s. 20. (2)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written complaint concerning the care of a resident was immediately forwarded to the Director.

The Administrator provided Inspector #551 a copy of a Complaint Investigation Form for specified date in February 2015 when Resident #052's Power of Attorney (POA) made a complaint to the home.

On a specified date in February 2015, Resident #052's Power of Attorney (POA) sent an email to the Administrator entitled Concerns for Resident #052 with one attachment to the email. The attached file included concerns related to missing clothes, inadequate clothing and grooming and an incident from the Fall 2013 when Resident #052 was not accounted for in the home.

The written complaint was not forwarded to the Director until six days later.

During an interview with the Administrator, he indicated that he was aware of the need to report certain matters immediately to the Director but was not aware of the need to submit written complaints as indicated in this provision.(Log # O-002694-15) [s. 22. (1)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #027 receive fingernail care, including the cutting of fingernails.

On December 15, 2015 Inspector #547 observed Resident #027 with dry, chipped and sharp finger nails that were bothering the resident, as he/she was rubbing his/her nails and picking at them to try to peel them off. Inspector #547 informed PSW #109 that the resident's nails were sharp and long, and that he/she would like to have nails trimmed.

On December 16 and 17, 2015 the resident's finger nails remained dry, chipped and sharp.
On December 17, 2015 Inspector #547 interviewed PSW #104 caring for the resident and indicated that the resident's nails should be trimmed during baths, that are provided twice a week on evenings. PSW #104 further indicated that Resident #027's nails were long and jagged, and required trimming today, and would ensure they are done as soon as possible to prevent the resident from injury.

Inspector #547 interviewed the Clinical Nurse regarding Resident #027's nails, and she indicated that all PSW's are responsible to provide hand care with morning care, and if they notice Resident #027's nails in this state, that they should have trimmed or filed them for the resident's safety. The Clinical Nurse did indicate that the residents nails should have been trimmed with bath however they were visibly not done. Review of the resident care flow sheets for the week prior to this observation with the Clinical Nurse and noted that no initials of any nail care was provided to the resident. [s. 35. (2)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee failed to ensure that each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence.

The health care record of Resident #50 indicates that the resident requires total care for toileting and two staff to assist with transferring. Further to this, the resident is capable of asking staff when he/she needs to go to the bathroom, but has inadequate control of bladder and wears incontinent products.

On December 18, 2015, at 1018 hours, Inspector #148 observed the communication system to be activated in Resident #50's bedroom. At 1035 hours, the communication system remained activated as staff had yet to respond. At this time Inspector #148 approached Resident #50, who had activated the call bell, and the resident indicated the need to go to the bathroom and that he/she was holding it. Inspector #148 approached PSW #125, who had been in close proximity to room 124, providing care and assisting in the tub room during the Inspectors observations. The Inspector informed PSW #125 of the activated communication system and that Resident #50 had expressed a need to use the bathroom. PSW #125 had indicated that the activated communication system did not present on his pager as the batteries were low. PSW #125 then approach Resident #50 who indicated to the PSW the need to go to the bathroom. PSW #125 indicated he would go and get someone to help and then turned off the activated communication system.
At 1040 hours, Inspector #148 continued to observe the area and noted that PSW #125 and PSW #124 were in close proximity to room 124, providing care and assisting in the tub room where a third staff member was providing bathing assistance. There is a fourth staff member, PSW #127, providing the morning nourishment pass who was located mid-way down the hallway, at this time.
At 1049 hours, the Inspector approached the resident. The resident indicated that he/she still needed to go to the bathroom. When asked, the resident was able to recall that a man had been in and told the resident that he had to find someone else to help. The resident was aware that he/she needed two staff persons to assist in toileting. The resident then indicated that he/she is wet.
At 1052 hours, PSW #127, approached room 124 to provide nourishment. PSW #127 provided nourishment and left the room to continue down the hallway.
At 1100 hours, the Inspector spoke with PSW #127 after having completed the nourishment pass. When asked about the previously activated communication system in room 124, she indicated that she was not carrying a pager. She further indicated that she

was approached by PSW #125 and told that Resident #50 required toileting. She reported that she told PSW #125 that she would attend to Resident #50 after she had finished her nourishment pass. Writer noted the time of initial activation of the communication system and PSW #127 indicated she would return her nourishment cart and then come back to assist Resident #50.
At 1102 hours, PSW #127, with the assistance of PSW #124, provided toileting assistance to Resident #50. Inspector confirmed with PSW #124 that the resident's incontinent product was soiled.
Resident #50, who is unable to toilet him/herself independently, did not receive assistance from staff to maintain continence on the morning of December 18, 2015.

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to consult regularly with the Family Council, and in any case at least every three months.

The home's Family Council was re-established at a meeting on May 26, 2015. The council of approximately eight family members were meeting monthly since that date and minutes were posted in the activity rooms of the home, as indicated by the Assistant to the Family Council.

During an interview with the President of the Family Council, he indicated that licensee did not consult with the Family Council until November 24, 2015 when the Acting Director of Care and the Assistant were invited to participate at the council's meeting. He indicated that the licensee did not consult regularly with the Family Council, and in any case not every three months.

The Administrator indicated to the Inspector that he was the representative of the licensee. He indicated that he believed that the Family Council had not yet been formerly established. He indicated he was not aware that the minutes were posted in the activity rooms of the home since May 2015. He further indicated that he had met with the President this week and requested an invitation to speak at a Family Council meeting. [s. 67.]

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that required information, including the home's policy to promote zero tolerance of abuse and neglect of residents, notification of the home's policy to minimize the restraining of residents and the licensee's name and telephone number are posted in the home.

On December 14, 2015, Inspector #148 conducted an initial tour of the home. At the time, only one page of an eight page policy to promote zero tolerance of abuse and neglect of residents, dated July 2012, was found to be posted. Upon further observation on December 16, 2015, in the presence of the home's DOC and Administrative Assistant, it was noted that a second policy of abuse was posted in the South Wing activity room. This policy titled Resident Abuse – Staff to Resident, was dated November 2013 and only contained odd numbered pages of the eight page document. Upon the request of Inspector #148, two policies, both #OPER-02-02-04 and dated November 2013, were identified by the home's DOC as the home's policy to promote zero tolerance of abuse and neglect of residents. One policy was titled Resident Abuse – Staff to Resident and the second was titled Resident Abuse by Persons Other than Staff. Neither of these policies were found to be posted in their entirety.

In addition, on December 16, 2015, it was confirmed that the home does not have notification of the home's policy to minimize the restraining of residents. It was also determined that the name and telephone number listed with the home's required postings included the home's name and home's telephone number. Contact name and telephone number for the licensee were not posted. [s. 79. (3) (c)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following:

s. 88. (1) As part of organized programs of housekeeping and maintenance services under clauses 15 (1) (a) and (c) of the Act, every licensee of a long-term care home shall ensure that an organized preventive pest control program using the services of a licensed pest controller is in place at the home, including records indicating the dates of visits and actions taken. O. Reg. 79/10, s. 88 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 88 (1) in that the licensee has failed to ensure that an organized pest control program is in place at the home, including records indicating the dates of visits and actions taken.

On December 17th, 2015, at 4:10pm, in resident #018's bedroom, Inspector #133 and Inspector #545 observed at least twenty five small ants on the floor in front of the resident's dresser, around the garbage can. There was no obvious source for the ants. On December 18th, 2015, at 4:40pm, Inspector #133 returned to resident #018's bedroom and observed at least ten small ants in the same area, concentrated around two small pieces of debris. Inspector #133 observed the ants for several minutes and noticed they were going down in between the floor tiles, in front of the dresser, and watched as some came up from the space. The inspector obtained a straw from nursing staff and was able to push it down, between the tiles, for approximately two inches. On December 22nd, 2015, Inspector #133 brought the Administrator and the Maintenance Manager (MM) to resident #018's bedroom to show them the area in front of the resident's dresser. The MM informed that he was not aware of any reports of ants in this bedroom. The MM explained that pest sightings are supposed to be documented in the pest control binder in the front office to allow for follow up by the pest control technician at the next visit. The MM explained that ants had been an ongoing issue for this home over the years, and it is due to the grounds the home was built upon.

On December 22nd, 2015, the Administrator provided the inspector with the pest control program contract. The Administrator explained to the inspector that the contract had been in place when he became the Administrator, in 2014, and he had not yet found the time to fully review the program. On the contract, "kitchens" was listed as the common areas to be inspected. No other areas were specified to be a part of the monthly service. The contract also listed nine different types of pests covered for the common areas covered by the contract, including ants. The contract included an additional clause, which specified that there was a charge of twenty five dollars for extra rooms.

On December 22nd, 2015, the inspector obtained the pest control binder from the main office and reviewed the "extermination customer communication sheets". Concerns related to pest sightings, typically ants, were documented on these sheets for the review of the pest control technician. For 2015, in March, there were four bedrooms and a common area in which there were reported ant sightings. There was one sighting in one bedroom in April, and one in May. In July, there were two bedrooms in which there was a reported ant sighting and a possible cockroach sighting in another bedroom. In October, there were five bedrooms in which there were reported ant sightings.

Within the pest control binder, there was also a section, titled "log book", where the pest control technician recorded dates of visits, the service, the pesticide used and the technicians initials. In January 2015, the technician's log book indicated that "monthly service" was provided. In February 2015 the documented service was for ants in three bedrooms, for which there were no documented sightings with the exception of one of the bedrooms, where there was a documented sighting in December 2014. In March 2015, the documented service was for ants in one bedroom (of the four bedrooms in which there was a documented sighting that month). In April 2015, the documented service was for ants in one bedroom, in which there had been a documented sighting, as well as a "monthly service". From May 2015 – December 2015, the documented service was "monthly service".

Records within the pest control binder did not include actions taken during monthly service visits. As well, documented pest sightings for three of the four bedrooms listed for March, and for bedrooms listed for May, July and October 2015 did not appear to have been followed up on, as there was no mention of the specified rooms in the technician's documentation.

On December 22nd, 2015, the inspector and Administrator discussed the pest control binder log book entries and it was agreed that they did not detail actions taken during monthly service visits or ant service visits. As well, it was agreed that it did not appear that documented pest sightings were being followed up on. The Administrator indicated he would contact the pest control company for explanation about the lack of follow up. The Administrator later explained to the inspector that he had forgotten having had a discussion with the pest control technician at some point in 2015, possibly in September, to the effect that there was supposed to be an extra charge of twenty five dollars per bedroom serviced. The Administrator explained that as a result, he had directed the technician not to provide service to the bedrooms. Documented pest sightings in the bedrooms were not followed up on by the pest control technician. The Administrator explained that he had intended to further follow up, and explore other options, with a focus on preventative treatments related to the ants as opposed to only responsive treatments based on sightings, but had never done so.

On December 23rd, 2015, the inspector spoke with the Office Manager (OM), who explained that she was the person who had documented pest sightings on the communication sheets, within the pest control binder, up until October 2015. Entries for October were made by the Maintenance Manager. The OM explained that she typically

received reports of pest sightings from residents, their families or visitors, and housekeeping staff. The OM said she had assumed the documented pest sightings were being actioned monthly by the pest control technician.

The Office Manager provided the inspector with the monthly invoices for the pest control service. At the bottom of the invoices, for January – June 2015, August – October 2015, and for December 2015, the technician checked off the "inspection" and "insect monitors" boxes. There was no other information about where or what the technician inspected or where insect monitors were placed or inspected. For the July and November 2015 invoices, the technician did not check off any of the boxes. As per the log book section of the pest control binder, the technician indicated "monthly service" for these two months. The monthly invoices did not provide any further explanation as to actions taken during monthly service visits or ant service visits.

On December 23rd, 2015, the inspector spoke with the Maintenance Manager who informed that despite the limited pest control contract, he routinely saw the technician go through other common areas of the home, not just the kitchen. He brought the inspector to all the areas he has seen the glue boards that are used to monitor an area for pests, this included the bathroom in the main lobby, areas within the kitchen, the west servery, the bathroom in the basement, the chapel, several areas in the staff room, several areas within the laundry room, the dry storage room and the mechanical room.

On December 23rd, 2015, a technician from the pest control company was into the home and provided service, focused on ants, in seven resident bedrooms, including the five bedrooms noted to have had ant sightings in October 2015, and resident #018's bedroom. It was the technician's first time in the home, and he explained that the regular technician was too busy to provide service to the home today, as was requested by the Administrator on December 22nd, 2015. The technician was unable to answer any questions about the home's pest control contract or the routine monthly service [s. 88. (1)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the response to a written complaint concerning the care of a resident indicated that the licensee believes the complaint to be unfounded and the reasons for the belief.

On a specified date in February 2015, Resident #052's Power of Attorney (POA) sent an email to the Administrator entitled Concerns for Resident #052 with one attachment to the email. The attached file included concerns related to missing clothes, inadequate clothing and grooming and an incident from the Fall 2013 when Resident #052 was not accounted for in the home.

On a specified date in February 2015, the Administrator responded to the complainant and his letter included the following statement:" We made every attempt to find the missing items and make persistent attempts to safeguard all personal items of the resident. We are not able to substantiate that these items were missing".

The response did not provide reasons for the belief that the items were not in fact missing and therefore the complaint unfounded. Furthermore, the response did not address the POA's other concerns regarding inadequate care provided to Resident #052 in regards to dressing and grooming, or to the issue related to Resident #052 being unaccounted for in the home in Fall 2013.

During an interview with Resident #052's POA, he/she indicated to Inspector #551 that the home's response to this complaint was not satisfactory and stated that his/her concerns remained ongoing.(Log #O-002694-15) [s. 101. (1) 3.]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day when a resident was missing for less than three hours and returned to the home with no injury or adverse change in condition.

Resident #052's POA indicated to Inspector #551 that in the fall of 2013, the resident was missing for approximately a two (2) hour period. In a complaint submitted by Resident #052's POA to the Administrator in February 2015, the POA indicated to still be concerned about this incident having occurred.

A review of the progress notes indicated that on a specified date in the Fall 2013, Resident #052 was unaccounted for, for approximately a two hour period in the evening. Following a search by staff and the resident's family member, Resident #052 was found outside the home, sitting on the ground and crying.

During an interview with the Administrator, he indicated that as part of the home's investigation into the complaint submitted by the resident's POA in February,2015, that he did not look into the incident as too much time had passed. The Administrator stated that he was not employed in the home at the time of the incident and assumed that the previous Administrator would have dealt with the situation, although he had nothing in writing.

A review of Critical Incident Report submissions indicates that the incident of the missing resident was never reported to the Director.(Log #O-002694-15) [s. 107. (3) 1.]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area of the home or a medication cart that is secure and locked.

On December 13, 2015 Inspector #547 observed several prescribed creams/ointment in a basket located on the top of a locked medication cart of the West wing hallway from 12:30 to 12:50 unattended by any registered nursing staff. Five containers of prescribed creams/ointments for residents in the home were noted inside this basket.

RN #103 indicated to Inspector #547 that she left this basket of prescribed creams/ointments on top of the medication cart during the lunch meal, as registered nursing staff are not allowed to lock prescribed creams/ointments in the medication carts in the home. Inspector #547 further noted that there was also two bottles of oral medications for Resident #006 and Resident #030 in this prescribed creams/ointment basket.

On December 15, 2015, Inspector #545 observed a container of prescribed cream located on Resident #018's night table.

On December 16, 2015 Inspector #592 observed a container of prescribed cream in a pink basket in Resident #036's shared bathroom.

On December 15, 2015 the DOC indicated to Inspector #547 that the home's practise is to ensure that all prescribed creams/ointments are kept locked inside the treatment cart for Registered Nursing staff to apply to residents. The DOC further indicated that the two prescribed medication bottles should have been locked inside the resident's drawers inside the locked medication cart before RN #103 stepped away from her cart. [s. 129. (1) (a)]

WN #26: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the home's infection control program.

On December 14, 2015, Inspector # 547 observed Resident #029's catheter bag hanging off the towel rack to the left of the sink on top of a hand towel, and the tubing was resting on top of a used facecloth of the shared bathroom. The catheter tubing was also noted to not have any connector tubing caps on either ends of tube.

On December 14, 2015, Inspector #545 observed in Resident #019's shared bathroom, a catheter bag hanging on a towel rack with the tubing resting on a towel with no connector tubing caps on either ends of tube.

On December 16, 2015, Inspector #592 observed in Resident #019 and #029's shared bathrooms, catheter bags hanging off the towel racks with hand towels in both rooms and none of the catheter bags had a cap to protect the catheter connector tubing.

On December 16, 2015 in an interview with PSW #106, she indicated to Inspector #592 that PSW staff were responsible to change residents day and night catheter bags for Residents #019 and #029 and that they were instructed to clean the bags with hot water/ vinegar and disinfect the tube connectors with alcohol swabs and then hang them to dry in the bathrooms. PSW #106 further indicated that a cap needs to cover the tube connector for catheter bags to prevent infection.

On December 16, 2015 in an interview with RPN # 107, she told Inspector #592 that Registered nursing staff were responsible to change catheters monthly and to provide residents with a new catheter bags on a weekly basis. RPN #107 indicated that catheter bags were to be hanging in the washroom with a cap on the catheter tube connectors to prevent infection.

On December 16, 2015, Inspector #592 interviewed the Clinical Nurse regarding education that was provided to PSW's for care of catheter bags and tubing and she indicated that the PSW's were aware that they have to cap the catheter connector tubes for the prevention of infection.

On December 17, 2015 the DOC indicated to Inspector #592 that the home's expectation for urinary catheter collection bags and tubing was that the tubing connector for all

catheter bags are to be covered with a cap to avoid any contamination to a resident. The DOC further indicated that for infection control and hygiene purposes the catheter bags and tubing should not be hung on the towel racks with towels. [s. 229. (4)]

Issued on this 10th day of February, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA KLUKE (547), AMANDA NIXON (148), ANGELE ALBERT-RITCHIE (545), JESSICA LAPENSEE (133), MEGAN MACPHAIL (551), MELANIE SARRAZIN (592)
Inspection No. / No de l'inspection :	2015_286547_0025
Log No. / Registre no:	033518-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 25, 2016
Licensee / Titulaire de permis :	CVH (No.4) GP Inc. as general partner of CVH (No.4) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes Inc., CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	MANOIR MAROCHEL 949 MONTREAL ROAD, OTTAWA, ON, K1K-0S6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bipin Raut

To CVH (No.4) GP Inc. as general partner of CVH (No.4) LP, 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. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Order / Ordre :

(1) The licensee is required to ensure that the home is equipped with pagers to meet the nursing and personal care needs of residents, which are connected to the resident-staff communication and response system that are readily available.

(2) The licensee shall develop an auditing process to ensure that PSW staff are utilizing functional pagers for Resident-Staff communication and response system including a written process to ensure batteries for these pagers are verified at the beginning of each shift.

(3) Until such time that the licensee is in full compliance with O. Reg. 79/10, s.44, formalized measures shall be taken by the licensee, to ensure vigilance of resident safety by staff, through regular enhanced monitoring intervals, of the identified rooms that are assigned to staff members which are not in possession of a functional pager connected to the resident-staff communication and response system.

Grounds / Motifs :

1. The licensee has failed to ensure that supplies, equipment and devices such as functional pagers, are readily available at the home to meet the nursing and personal care needs of residents.

For the purposes of this report, pagers are used by nursing staff to enable the resident-staff communication and response system by directly notifying nursing staff when a call for assistance has been made by a resident.

On December 14, 2015 at 13:05pm, Inspector #592 observed the dome light outside of a resident's room illuminating on the South unit. After 7 minutes, the

dome light was still illuminating and no staff were noted to be around. Inspector #592 noted PSW #130 in the hallway and upon asking her about the call bell in this resident's room, she told Inspector #592 that she was not in possession of her pager as it was broken. Inspector #592 interviewed RPN #129 who was at the nurses station and indicated that he does not carry any pagers but that he relied on the dome light outside of the resident rooms. RPN #129 stepped out of the nurse's station and told Inspector #592 that there was no call light activated as there was no dome light illuminated. Inspector #592 noted that there was a wall mounted fan at the front of the dome light, therefore the activated dome light was impossible to be viewed. RPN #129 further indicated to Inspector #592 that he relied on the board in the nurses station as well and indicated to Inspector #592 the light on the call bell board. RPN #129 indicated to Inspector #592 that he would send someone to answer the call bell in this resident's room.

On December 14, 2015 at 11:56 am, Inspector #545 activated the call bell in a shared bedroom on the West unit which did result in the illumination of the dome light outside of the resident's bedroom. PSW #103 arrived 5 minutes later and informed Inspector #545 that he saw the dome light outside the residents room, but did not hear it as he has no batteries in his pager today. He further informed Inspector #545 that he left his pager at the nursing station after breakfast today, expecting management to replace the batteries. Inspector #545 spoke with PSW #103 later on that same day upon activating another call bell on the West unit as PSW #103 arrived several minutes after and told Inspector #545 that he saw the dome light flashing but that he was not in possession of his pager as it was still not available to him; therefore he did not carry a pager during his day shift.

On December 14, 2015, at 14:50 pm, Inspector #547 activated two call bells in Resident rooms on the West unit which resulted in the illumination of the dome light outside of these resident bedrooms. After 5 minutes, Inspector #547 went to look for staff members and approached PSW #111 who informed Inspector #547 that she was working on the unit and that she was not in possession of her pager as it was broken. PSW #111 further indicated that her co-worker PSW #103 had lost his pager and that they are both assigned to group #4. PSW #111 indicated they know to look in the hallway to see dome lights lit. PSW #103 and #111 told Inspector #547 that at 14:00 pm, they sit at the end of the hallway at a desk to do their charting, and they are able to look up to see bell lights. It was noted that both staff members remained seated at this desk at the end of the hallway and confirmed with Inspector #547 that they did not notice the dome lights for these resident rooms. In an interview with evening PSW #112 who was

distributing the beverages for residents on that same unit,she told Inspector #547 that she is not in possession of a pager until 15:00 pm, as she arrived at 14:00 pm to do snack pass and was not responsible for residents or to respond to call bells until 15:00 pm.

On December 14, 2015, at 15:45 hours, Inspector #545 activated a call bell in a shared bedroom on the West unit, which did result in the illumination of the dome light outside of the resident's bedroom. After 5 minutes, PSW #132 arrived in the room and Inspector #545 asked PSW #132 to show the display on the pager, the pager was blank and did not identified any room number. PSW #132 indicated that the pager's batteries were probably dead.

On December 15, 2015, at 14:05 pm, Inspector #545 activated a call bell in a shared bedroom on the West unit which did result in the illumination of the dome light outside of the resident's bedroom. PSW #125 arrived 6 minutes after and told Inspector #545 that he just saw the light flashing but that he was not in possession of his pager as it was broken and gave it back at the morning report to the RAI coordinator and that the pager had not been return to him.

On December 16, 2015 the Administrator informed Inspector #133 that 4 new pagers were ordered as a result of the last Ministry Of Health and Long-Term Care inspection conducted on October 1, 2015 for this same issue resulting in a voluntary plan of correction required by the home. The new pagers were picked up by the Office Manager on December 3rd, 2015 and the home was informed on December 11, 2015 by the outside vendor, that the new pagers could not be configured to the system due their company staffing issues and being unable to reconfigure the pager system for now. The Administrator informed Inspector #133 that the home plans to implement a contingency plan in the meantime, involving the use of walkie talkies that were bought yesterday. The home is planning to start the distribution of the walkie talkies tomorrow as they will be fully charged, while waiting for the pager system to be configured. A note was left to all staff members by the DOC at the nurses' station with the instructions for the walkie talkies system.

On December 18, 2015, at 10:18 hours, Inspector #148 observed the communication system to be activated in a resident's room on the South wing. At 10:35 the communication system remained activated as staff had yet to respond. At this time Inspector #148 approached Resident #050, who had activated the call bell, and the resident indicated the need to go to the bathroom

and that he/she is holding it as best as the resident can. Inspector #148 approached PSW #125, who had been in close proximity to this resident's room, providing care and assisting in the tub room during the Inspectors observations. The Inspector informed PSW #125 of the activated communication system and that Resident #050 had expressed a need to use the bathroom. PSW #125 indicated that the activated call from this resident room did not present on his pager as the batteries were low and needed to be charged, demonstrating that no calls were present on his pager.

The Administrator and the RAI coordinator confirmed with Inspector #592 that there should be a functional available pager for every PSW on the floor and that three of eight pagers were not available for use by nursing staff at the time of the inspection. These pagers are connected to the resident-staff communication and response system which directly notifies nursing staff when a call for assistance by the resident has been made. This presents a widespread issue in the home for residents care needs to be met when they cannot communicate with the nursing staff that care for them.
(592)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 29, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that at least one Registered Nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

This plan shall include all recruiting and retention strategies and the home's staffing plan to address the backup coverage for managing absenteeism for Registered Nurses.

This plan must be submitted in writing by February 1, 2016 to the Ministry of Health and Long- Term care.

Grounds / Motifs :

1. The licensee has failed to ensure that there was at least one Registered Nurse (RN), who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

A review of Manoir Marochel's RN Staffing Schedule for the period of September to December 31, 2015 was reviewed and indicated the following:

On three specified dates in October, 2015, the home did not have an RN to work in the home on the day shift
On another specified date in October, 2015, the home did not have an RN to work in the home on the evening shift

On a specified date in November, 2015, the home did not have an RN to work in the home on the evening shift
On another specified date in November, 2015, the home did not have an RN to work in the home on the night shift
On another specified date in November, 2015, the home did not have an RN to work in the home in the day shift
On three specified dates in December, 2015, the home did not have an RN to work in the home on these day shifts
On another specified date in December, 2015, the home did not have an RN to work in the home on the evening shift

Manoir Marochel is a 64 bed Long-Term Care Home.

Ontario Regulation 79/10 section 45 (2) indicates that "emergency" means an unforeseen situation of a serious nature that prevents a Registered Nurse from getting to the Long-Term care home.

Each of the eleven shifts when there was no RN working in the home were reviewed with the Office Manager, who is in charge of scheduling, and none were due to an emergency. The Office Manager indicated that she attempts to replace an RN shift with an RN but when this is not possible, the RN shift is covered by a Registered Practical Nurse (RPN). (551)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 29, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 25th day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Kluke

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