Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 03, 2019	2018_605213_0022 (A1)	004767-18, 005643-18, 006828-18, 007310-18, 007753-18, 010785-18, 010788-18, 010805-18, 016402-18, 016787-18, 017003-18, 017004-18, 024983-18, 029244-18	Critical Incident System

Licensee/Titulaire de permis

Maplewood Nursing Home Limited
73 Bidwell Street TILLSONBURG ON N4G 3T8

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

Maple Manor Nursing Home
73 Bidwell Street TILLSONBURG ON N4G 3T8

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

Amended by RHONDA KUKOLY (213) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The Administrator requested an extension of the compliance date for Order #001 related to bed rails. An extension to February 28, 2019 was granted.

Issued on this 3 rd day of January, 2019 (A1)

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

Original report signed by the inspector.

Ontario

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

Amended by RHONDA KUKOLY (213) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 6, 7, 8, 9, 13, 14, 2018.

This inspection was completed related to the following:

Log #004057-18 Critical Incident #1049-000002-18 related to a missing resident

Log #005643-18 Critical Incident #1049-000003-18 related to a fall

Log #006828-18 Critical Incident #1049-000004-18 related to a fall

Log #006932-18 Critical Incident #1049-000005-18 related to a fall

Log #007310-18 Critical Incident #1049-000006-18 related to a fall

Log #010785-18 Critical Incident #1049-000012-18 related to a fall

Log #010788-18 Critical Incident #1049-000013-18 related to a fall

Log #016787-18 Critical Incident #1049-000020-18 related to a fall

Log #020836-18 Critical Incident #1049-000021-18 related to an altercation between residents

Log #028572-18 Critical Incident #1049-000023-18 related to alleged resident to resident abuse

Log #029244-18 Critical Incident #1049-000024-18 related to a medication incident

Log #007753-18 Complaint Infoline #IL-56500-LO related to short staffing

Log #016402-18 Complaint Infoline #IL-57787-LO related to short staffing

Log #024983-18 Complaint Infoline #IL-59846-LO related to short staffing

Log #004767-18 Follow up to Compliance Order #001 issued in inspection #2018_678680_0005 related to the continence program

Log #017003-18 Follow up to Compliance Order #002 issued in inspection #2018_607523_0013 related to bed rails

Log #017004-18 Follow up to Compliance Order #001 issued in inspection #2018_607523_0013 related to reporting to the Director

Inspectors #741 and #745 participated in this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, a Registered Dietitian, an office assistant, maintenance staff and residents.

The Inspectors also made observations and reviewed health records, policies, education records, human resource records, schedules and other relevant documentation.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Medication
Safe and Secure Home
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
- **9 WN(s)**
- **3 VPC(s)**
- **3 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
O.Reg 79/10 s. 48. (1)	CO #001	2018_678680_0005	524

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 15. Bed rails
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was reassessed and his or her bed system evaluated in accordance with evidenced-based practices, and if there were none, in accordance with prevailing practices to minimize the risk to the resident.

Compliance Order #002 was issued during inspection #2018_607523_0013 on July 12, 2018 to comply with LTCHA 2010, s. 15(1)(a) with a compliance date of August 31, 2018. Specifically, the licensee was ordered to:
a) Ensure that where bed rails are used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.
b) Ensure that all registered staff are trained to assess residents and evaluate their bed system in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

a) The policy "Resident Bed Rail Assessment Risk for Entrapment", dated June 30, 2018, was reviewed. It stated that prior to assessing a resident for use of assist rails, a bed entrapment assessment must be conducted with the rails in place. An evaluation tool for the use of bedrails was also to be used to determine the capability of a resident using assist rails.

The Director of Care (DOC) said the home contracted an external company to assess and evaluate the beds in their facility for entrapment. The assessors compiled a Facility Entrapment Report, which documented whether bed rails were in place, the type of rails, bed frame, mattress and zones of entrapment in 96 beds in the facility.

A random sample of 10 beds was chosen from the Facility Entrapment Report and Inspectors #213 and #741 observed if the bed frame, bed rails, and mattress listed in the report corresponded with the beds in the rooms. The following observations were made:
- An identified bed in an identified room was listed on the report to have no bed rails and a specific mattress, and it was found that the bed in that room was a different bed, with bed rails in place and a different mattress.
- Another identified bed in a second room was listed on the report to have no bed rails and a specific mattress, and it was found that the bed in that room was a different bed, with bed rails in place and a different mattress.
- Another identified bed in a third room was listed on the report to have no bed

rails and a specific mattress, this was found to be in place during the observation

A record review of the "Bed Rail Risk Assessment" and plan of care for the resident who resided in the third room, was completed. There were two Bed Rail Risk Assessments found for a resident, one with a specified date indicating an annual assessment and recommendations to use two quarter repositional rails, care plan updated indicated "yes". The other assessment was not signed or dated, did not indicate the type of assessment, indicated recommendations to use assist rails, did not indicate how many rails to be used, and care plan updated indicated "no".

One staff member, who had received training for assessing beds for entrapment, said that when there was a new admission, a resident returned from hospital or there was a change in the bed system, they or the other staff member also trained for assessing beds, completed a "Bed System Measurement Device Test Results Worksheet". They said that the bed system was assessed using a tool to test for risk of entrapment and the worksheet was completed and given to the DOC. The staff member said that they did not update the "Facility Entrapment Report" at any time.

Inspector #213 and #741 asked the staff member about the discrepancies with the documentation and observations for the beds in the two rooms. The staff member stated that the bed in the first room was not the bed listed on the report. The staff member said that the bed in the second room was assessed using the "Bed System Measurement Device Test Results Worksheet".

The DOC provided a binder of "Bed System Measurement Device Test Results Worksheet" sheets. Included in the binder was a sheet with a specific date indicating the bed had bed rails in use that passed all zones. There was a print out of an email from SFI Medical to the home with a specific date indicating one bed in an identified room required troubleshooting and repair. There was no worksheet for this bed. The second bed was noted to be listed on the "Facility Entrapment Report" in a different room.

Also in the binder of bed system measurement worksheets, the following worksheets were found with missing information:
- One identified room no bed number indicated
- One identified a bed number, no room number indicated
- Another identified a bed number, no room number indicated

In an interview with the DOC, they stated that the bed in the first room likely been replaced with a new bed. The DOC reviewed the Facility Entrapment Report with the inspectors #213 and #741 and stated that it was not up to date. The DOC was not able to find a bed system measurement worksheet for the first bed that was being used by an identified resident and said there should have been an assessment completed for that bed and that resident.

b) In an interview with the DOC related to the staff training required in the order, the DOC stated that bed entrapment was reviewed with registered staff in June 2018 and that the full training was provided to registered staff in October 2018.

The sign in sheet titled "Education Bed Rail Entrapment Side Rail Assessment 2018" was reviewed by Inspectors #213 and #741 and it showed signatures of completion for nine out of twenty registered staff with dates ranging from June 26 to July 19, 2018.

The sign in sheet titled "Inservice Maple Manor LTC Bed entrapment Review and Side Rail Evaluations, Continence Care and Bowel Management Program, Policy NDM-111-240 Nursing Manual, Perineal Care, Pharmacy: Opiods and Overdose Naloxone Education, October 17, 2018" was reviewed by Inspectors #213 and #741. The sheet included 11 registered staff names. The registered staff schedules were reviewed and noted that there were 24 registered staff (Registered Nurses and Registered Practical Nurses) working in the home. The DOC stated that not all of the registered staff received the training by the compliance order date of August 31, 2018 or by the date of the follow-up inspection.

The licensee has failed to ensure that where bed rails were used, the resident was reassessed and his or her bed system evaluated in accordance with evidenced-based practices, and if there were none, in accordance with prevailing practices to minimize the risk to the resident for two identified beds and one identified resident. In addition, documentation bed system evaluation was unclear and not up to date. [s. 15. (1) (a)]

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and the Regulation.

The Ministry of Health and Long Term Care received three anonymous complaints between April and September 2018 related to concerns about the home being short staffed and baths not being provided.

The "Scheduling of Staff Nursing Department" policy with a revised date of March 2018, was reviewed and stated: The departments staffing plan and staff schedules based on the departmental budget allocation, and regular schedules where all shifts are covered by qualified facility staff in accordance with provisions in the collective agreement requirements under the Long Term Care Homes Act (LTCHA), Ontario Regulation 79/10 section 31(3), resident safety criteria and the efficient and effective operation of the home.

The "Guidelines for Calling Relief" policy with a revised date of October 30, 2018, was reviewed and stated:
- Supervisory staff shall endeavor to maintain a full complement of staff each shift in accordance with the authorized staffing pattern.

The "Shortage of Staff" policy with a revised date of April 2018, was reviewed and

stated:
- The overall concern is to maintain staff and Residents Health and Safety. When staffing level is not complimented to fullest, each floor will be rotated as when staff is working short. Therefore when one floor works short one day, the second floor will work short the next time. The alternating of floors will prohibit the same staff form working short on a regular basis and decrease the likelihood of injury.
- Registered staff is responsible to ensure this delegation is issued at the time of shift change when this is effective. The least seniority staff member either full-time or part-time will be the staff member to change floors if deemed necessary.

The "Shift Routine" and "Contingency Plans was reviewed and included the following as the home's staffing plan:
Day shift on each floor for first and second floor:
Registered Nurse (RN) – 1
Registered Practical Nurse (RPN) – 1
Personal Support Worker (PSW) – 5
Tub Person - 1
Floats – 2
Evenings on each floor for first and second floor:
RN-1
RPN-1
PSW-4
Float-1
Nights on each floor on first and second floor:
RN-1
PSW-4

A review of the home's staffing schedule for PSWs from August 1, 2018 to November 18, 2018 identified a lack of full staffing complement on a daily basis for PSWs. The home was not able to locate the paper schedules for first floor for the period of October 19 to 25, 2018 or for second floor for the period of October 22 to 28, 2018.
A review of the first floor PSW schedule from October 1, 2018 to November 18, 2018 showed 37 out of 42 days, the unit was short one to four PSWs.
A review of the second floor PSW schedule from October 1, 2018 to November 18, 2018 showed 39 out of 42 days, the unit was short one to four PSWs.

Inspector #745 requested the home's contingency plan for when staff were not able to come to work. The Director of Care (DOC) provided a document labeled

"Contingency Plan". It was reviewed and indicated direction and routines as follows:
DAYS:
- Each floor full complement of PSW staffing are:
Five PSWs start time 0600 hours to 1400 hours
One PSW start time 0615 hours to 1415 hours
Day Float PSW start time 0700 hours to 1300 hours
Day Tub Bath start time 0600 hours to 1300 hours
- Met with full time PSW's Oct 30, 2018 and discussed changing the number of residents in their charge from six groups to five groups and having the sixth PSW as a float who will attend to residents from each of the five groups.
- As full complement of staffing have been reduced to 5 instead of 6 due to staffing issues.
- PSWs work in a team to coordinate assistance from each other when needed instead of trying to find a co-worker for assistance.
- Morning breaks remain at 15 minutes, lunch breaks have changed to 45 minutes. Leaving three PSW's on the floor at a time.
- Residents two tub baths per week have been changed to two day tub baths. Evening tub baths are no longer due to lack of staffing.
- The PSW who is scheduled from 0615 hours to 1415 hours answer call bells and continue with incidental rounds while during the afternoon shift report.

EVENINGS:
- Each floor Full Complement of PSW staffing are:
Registered Staff assist in the dining rooms during supper on both floors
Four PSWs start time 1400 hours to 2200 hours
One PSW start time 1415 hours 2215 hours
- 2215 PSW will do rounding and answer call bells during the night report
- PSWs will assist residents with the nourishment cart and record intake
- One PSW will complete the remainder of baths between 1400 hours and 1700 hours
- PSWs will assist residents getting up from afternoon nap
- Breaks have been changed to two 30 minute breaks
- PSWs team up after supper and assist residents with their needs

NIGHTS:
- Full complement of PSW staffing are:
Four PSWs start time 2200 hours to 0600 hours
One PSW start time 2215 hours to 0615 hours

- The 0615 PSW answer call bells while days are in report
- PSWs start their rounds work in pairs

A review of the Medical Advisory Committee minutes for Sept 20, 2018 showed:
New Business:
Staffing crisis: shortage of PSWs. PSWs have been working 12 hour shifts. Tub bath personnel have been pulled to work on the floor. Many overtime hours have been established. Interviews conducted, potential employees do not show up for either interviews or orientation.
Job postings have been placed on Indeed for a fee. Numerous applications have been reviewed and interviews set up. Potentially by end of October all positions will be filled and with casual employees.

Inspector #745 reviewed weekly bath schedules for both first and second floor and noted the following:
Created by bath PSW and then administration staff update
Organized by days of the week, resident room numbers and names
Average of 16 to 18 baths per day per floor

The staff schedules for each floor were reviewed for the bath shifts for the period of October 1 to November 18, 2018. The home was not able to locate the paper schedules for first floor for the period of October 19 to 25, 2018 or for second floor for the period of October 22 to 28, 2018. The schedules showed:
- First floor: 17 out of 63 scheduled shifts had no bath staff scheduled or worked.
- Second floor: 33 out of 70 scheduled shifts had no bath staff scheduled or worked.

In an interview with a staff member by Inspector #745, when asked about staffing, they said the home was staffed well for registered staff, but there was definitely a problem for PSWs, they were constantly short and moving people around. Baths were unable to be done many days because it was the bath person who was sick. The staff member pointed to the shift schedule indicating one staff should be assigned a specific line responsible for tub baths from 0600 hours to 1300 hours each day on each floor. The staff member demonstrated that for the schedule from November 5 to 18, 2018 for second floor, seven out of fourteen days had "Tub Bath" staff filled in. When asked who handled staffing issues on each shift, they said administration staff, if during regular hours and registered staff after hours.

In an interview by Inspector #745, with a staff member, they explained that when a sick call was received, they would start making calls based on seniority. They would make verbal calls, or send out texts until they had exhausted the list. When asked who authorized overtime, they said the DOC if there, if not there then registered staff would get authorization to offer overtime.

In an interview with another staff member, by Inspector #745, they said staffing was bad and they were short staffed PSWs every day and every shift. They said staff were asked to stay longer, do 12 hour shifts instead of 8 hours and they offered overtime or people wouldn't stay. Vacation has been denied but then that made things worse and people just called in sick. When asked if care was affected because of short staffing, they said that they cut corners in personal care and baths didn't get done, as they rarely had a tub person. When asked what the expectation was if baths were not done, they responded there really was no direction, each PSW did what they could, bed bath, no bath, hands and face only.

In an interview with another staff member, by Inspector #745, they said sick calls were constant and staff were frustrated. They said evening shift was worse, family and residents complained but they just did the best they could. When asked how care was affected, they answered they didn't get their care done, they cut corners, baths weren't done as bath staff was pulled.

In an interview with another staff member by Inspector #745, they said they were responsible for creating the tub schedule and all residents who requested a tub bath were on the list for a bath twice a week. When asked what happened when short staffed, they answered if they were short four PSWs on a floor, the baths were cancelled as per the DOC, and that many days no one was even booked to complete baths. When asked who documented if baths were completed or not, they were unsure who did that. The staff member said that they stayed late a lot of days to get baths done, but couldn't all of the time. They also said second floor was worse, most days they have had no bath nurse.

In an interview with another staff member, by Inspector #745, they said they had a tub person, but the tub person was on modified duties and were not doing any baths at that time. They have been replaced but the new staff never came in, so they have been short many days. When asked what happens then if there was no bath staff, they responded that they did as many baths as they could on days and then the registered staff pass on what residents needed a bath on evenings, but that was impossible as they were also short on evenings.

In an interview with a resident by Inspector #745, when asked about baths, they said they were supposed to have two baths per week. They said they have missed four baths in the last two weeks; they've missed a lot of baths. A review of bathing documentation for this resident in Medecare showed they missed three out of four scheduled baths in a two week period.

In an interview with another resident, by Inspector #745, when asked about baths, they said they have missed so many baths they recently stopped counting at nine. They said they were supposed to have two baths per week. They said they missed lots of baths, they just get no bath, no communication at all. They said they were worried about getting an infection because of not getting baths. The resident said they enjoyed their baths, they liked to soak, but there was no time for that. The resident said that the bath nurse quit last week, that's why they didn't get their bath that day. A review of the bathing documentation for this resident in Medecare showed they missed three out of four scheduled baths in a two week period.

In an interview with another resident, by Inspector #745, when asked about baths, they said they didn't get anything in place of missing a bath. The resident was unsure of their usual bath day, but said a lot got missed. A review of bathing documentation for this resident in Medecare showed they missed two out of four baths in a two week period.

In an interview with another resident, by Inspector #745, when asked about baths, they said they were supposed to have two baths per week, and they were not sure when they last had a bath. They said they didn't think they have had many recently. The resident said they would ask the staff each day if they were going to get a bath and the answer was no, they were short staffed again. A review of bathing documentation for this resident in Medecare showed they missed two out of four scheduled baths in a two week period.

In an interview with another resident, the resident was not able to recall their bath schedule, when they had last had a bath or if baths had been missed. A review of bathing documentation for this resident in Medecare showed they missed three out of four scheduled baths in a two week period.

In an interview with Director of Care by Inspector #745 regarding staffing, they said that they have had retirements, medical leaves and maternity leaves. They

said the schedule would be put out two months in advance, and then people went off, they have been unable to replace them, specifically PSWs. When asked about cancelling baths, they answered if they didn't have the staff then they didn't do them, they were not sure what else to do. When asked if they were actively recruiting staff, they answered yes, they have been doing three to five PSW interviews per week, but they had people not show up for their interviews or they hired them and then they didn't come to orientation, or they started and quit. They said that they have posted jobs on Indeed and they went to a Tillsonburg job fair. When asked who authorized overtime, they said they did, the staff would call them on weekends and during the night to get authorization. When asked if they had a written staffing evaluation, they answered no, they didn't have that written. When asked how they knew baths weren't getting done, they said they knew the numbers were really high for baths not being done. The Inspector demonstrated on second floor, the bath shifts that were not filled on the schedule, and asked if the staffing plan met the assessed needs of residents and provided for them being bathed a minimum of twice a week, they said they'd have to say no. The Inspector asked about Medical Advisory Committee minutes, under new business indicating potentially by the end of October, all positions filled, they answered that they thought they had lots of applicants, but it hasn't worked. When asked if there was a plan to address the staffing shortages, they answered December 13, 2018 is the next Medical Advisory Committee meeting where it will be discussed again.

The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and the Regulation including when five residents were not bathed at a minimum twice a week by the method of their choice as a result of the home not being fully staffed as per their staffing plan.

The licensee also failed to have a back-up plan for nursing and personal care staffing that addressed situations when staff could come to work. The licensee also failed to keep a written record relating to each annual evaluation of the staffing plan in accordance with evidence based practices that included the date of the evaluation, the names of the persons who participated, a summary of the changes made and the date that those changes were implemented. [s. 31.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of a missing or unaccounted for controlled substance in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

The quarterly medication incidents review in the Medical Advisory Committee meeting minutes for the period of June, July and August 2018, was reviewed. The errors listed in the review included a missing controlled substance.

The Medication Incidents binder was reviewed and no medication incident was found related to a missing controlled substance.

The Ministry of Health and Long-Term Care (MOHLTC) Critical Incident System (CIS) was reviewed and there were no missing or unaccounted for controlled substances reported by the home in 2018.

The Director of Care (DOC) said that they could not find the medication incident related to the missing controlled substance, could not recall that incident and contacted the pharmacy. Pharmacy faxed a copy of the report to the home. The form was reviewed with the DOC and the Inspector and it indicated a missing controlled substance. When asked if the missing controlled substance was reported to the MOHLTC, the DOC said no.

Compliance Order #001 was issued on July 12, 2018 in inspection #2018_607523_0013 that stated: "The licensee must be compliant with s. 107(1) (2). Specifically the licensee must ensure that the Director is immediately

informed, in as much detail as possible in the circumstances, of an unexpected death, including a death resulting from an accident or suicide". The compliance date for this order was August 31, 2018.

In an interview with the Administrator, when asked if there have been any sudden or unexpected deaths since the order was served, the Administrator said no. When asked what the home did to comply the order, the Administrator said that they posted "Appendix A: Table 1: LTCHA Subsection 24(1) – Reporting Certain Matters to the Director" and "Appendix B: Table 2: Critical Incident Reporting under O Reg 79/10 subsections 107(1), (3.1), and (7)" in the nursing stations, along with a sheet titled "Clarification of Mandatory and Critical Incident Reporting Requirements".

The Administrator provided two sheets titled "Clarification of Mandatory and Critical Incident Reporting Requirements". There were nine registered staff signatures on one sheet and nine registered staff on the other sheet. The registered staff schedules were reviewed and noted that there were 24 registered staff (Registered Nurses and Registered Practical Nurses) working in the home.

Inspector #213 asked the Director of care (DOC) if there was any direction provided to staff to review the two tables of reporting requirements and sign that they have read and understood or if they were aware that it was their responsibility to call the after-hours line to report a sudden or unexpected death. The DOC said that the Administrator was responsible for the follow up to the compliance order related to reporting to the Director, they weren't sure what was done or not done related to that compliance order. When asked if there had been any sudden or unexpected deaths in the home since July 2018, the DOC said no.

When asked if there was any direction provided to staff to review the two tables of reporting requirements and sign that they have read and understood, the Administrator said no. When asked if that could be the reason why only 18 out of 24 staff signed the sheets, the Administrator said they couldn't say why all of the staff didn't sign the sheets. When asked if anyone followed to up ensure that all registered staff signed the sheets and were aware of their responsibility to call the after-hours line if there is an unexpected death, the Administrator said no, they didn't. When asked if there was any direction provided to registered staff that it was their responsibility to call the after-hours line for the MOHLTC if there was an unexpected death, the Administrator said no.

The licensee has failed to ensure that the Director was informed of a missing controlled substance no later than one business day after the occurrence of the incident, followed by the report required under subsection (4). The licensee also failed to take appropriate actions related to Compliance Order #001 issued in Inspection #2018_607523_0013 related to immediately reporting a sudden or unexpected death to the Director. [s. 107.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Findings/Faits saillants :

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

The licensee has also failed to ensure that the documented record was reviewed and analyzed for trends at least quarterly; the results of the review and analysis were taken into account in determining what improvements were required in the home; and a written record kept of each review and of the improvements made in response.
Three complaints were received by the Ministry of Health and Long-Care related to short staffing in 2018.

The home's complaint binder was reviewed and the inspector found the following:
1. A Resident/Family Concern Referral Form with a specified date and complaint related to medications. There was no follow up with the residents, the nurse or actions taken documented and the "response date" was blank. The form was signed by the Administrator.
2. A Resident/Family Concern Referral Form with a complaint from two residents related to medications. The date of the concern was blank and the response date was blank. The form was signed by the Director of Care.
3. A Resident/Family Concern Referral Form with a specified date and complaint related to medications. The "Response/Action Taken" section was blank with nothing documented. The response date was blank and form was not signed.
4. A Resident/Family Concern Referral Form with a specified date and a complaint from the family of a resident related to care concerns. The "Response/Action Taken" section indicated: 1. Investigate, 2. Follow up with Power of Attorney (POA), Personal Support Worker on vacation for one week and POA and resident notified. The "response date" was blank and the form was not signed.
5. A Family/Client Satisfaction Log contained seven complaints dating from February 2016 and the last one on the list dated July 18, 2017.
There was no documentation of any review or analysis of complaints for trends or improvements needed.

The Administrator and Inspector #213 reviewed the complaint binder including the four above noted complaint forms. The Administrator said that they initiated two of the four Resident/Family Concern Referral Forms. They agreed that the forms were not completed in full documenting all of the required information including dates of complaints received and resolved and follow up actions taken. When asked if complaints were reviewed and analyzed quarterly for trends and improvements needed, the Administrator said no.

The Director of Care (DOC) and Inspector #213 reviewed the complaint binder including the four above noted complaint forms. The DOC said that they initiated two of the four Resident/Family Concern Referral Forms. They agreed that the forms were not completed in full documenting all of the required information including dates of complaints received and resolved and follow up actions taken. When asked if complaints were reviewed and analyzed quarterly for trends and improvements needed, the DOC said no.

The home's "Resident Complaints/Concerns" policy #ADM-II-332 was reviewed. The policy was dated June 1, 2011 and indicated "Document the information on a Complaint Record". The home's policy did not indicate that the documented record is to be reviewed and analyzed for trends at least quarterly; the results of the review and analysis taken into account in determining what improvements are required in the home; and a written record kept of each review and of the improvements made in response.

The licensee has failed to ensure that a documented record was kept in the home that included the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant for four complaints received in 2018.

The licensee has also failed to ensure that the documented record was reviewed and analyzed for trends at least quarterly; the results of the review and analysis were taken into account in determining what improvements were required in the home; and a written record kept of each review and of the improvements made in response in 2018. [s. 101.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a documented record is kept in the home that includes the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions taken and any follow-up action required; the final resolution, if any; every date on which any response is provided to the complainant and a description of the response; and any response made in turn by the complainant, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the Long-Term Care Homes Act (LTCHA): it is a condition of every license that the licensee shall comply with this Act and every order made under this Act 2007, c. 8, s. 195 (12).

The licensee has failed to comply with Compliance Order (CO) #001 from inspection number 2018_678680_0005 served on March 5, 2018, with a compliance due date of July 2, 2018.

The licensee was ordered to do the following:
"The licensee must be compliant with O. Reg. 79/10, s. 48 (1) 3.
a) Fully implement a continence care and bowel management program.
b) Train all required staff on the program. Attendance records are to be maintained related to this training.
c) Ensure resident #022 and any other resident, had a continence assessment

completed with any change in their continence status."

The licensee failed to complete step b) of the Compliance Order.

In an interview with the Director of Care (DOC), Inspector #524 requested the education and training information related to CO #001. The home provided an in-service sign in document dated October 17, 2018, with eleven signatures which was confirmed as training on the continence care and bowel management program and other topics for registered staff.

In an interview with a registered staff member by Inspector #213. Inspector #213 showed the registered staff member the sign in sheet for the in-service on October 17, 2018, which included continence care and bowel management and asked them if they attended an in-service on this topic in the last six months and the registered staff member said no, they did not.

In an interview with the DOC, Inspector #524 asked if the in-service sign in document included all registered staff currently working at the home. The DOC compared the list against the registered staff schedule and said that four out of 11 registered nurses and seven out of 13 registered practical nurses had attended the in service session. The DOC acknowledged that the education was on-going but that not all registered staff had completed the training as per the compliance order.

A review of the registered staff in-service document provided showed that 11 out of 24 or 46 per cent of staff had not received the training related to the continence care and bowel management program.

The licensee has failed to comply with Compliance Order (CO) #001 from inspection #2018_678680_0005 served on March 5, 2018, with a compliance due date of July 2, 2018.
[s. 101. (3)]

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 comply with the following requirement of the Long-Term Care Homes Act (LTCHA): it is a condition of every license that the licensee shall comply with this Act and every order made under this Act 2007, c. 8, s. 195 (12), to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health; reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, reviewed and analyzed; corrective action taken as necessary; and a written record kept.

The quarterly medication incidents review in the Medical Advisory Committee meeting minutes for the period of June, July and August 2018, was reviewed. The errors listed in the review included a missing controlled substance.

The Medication Incidents binder was reviewed and no medication incident was found related to a missing controlled substance.

The electronic Medication Administration Record (eMAR) was reviewed for the month the incident and the resident had an order and direction for a controlled substance.

The Director of Care said that they could not find the medication incident related to the missing controlled substance and contacted the pharmacy. Pharmacy faxed

a copy of the report to the home. The form was reviewed with the DOC and the Inspector and it indicated that nothing was checked off or completed on the form for physician, resident, family notified, Director of Care or designate signature or follow up actions. The DOC said that they were on vacation at that time and they were not aware of what actions were taken to assess and maintain the resident's health, if it was reported to anyone, if it was reviewed by anyone or any corrective actions taken.

The progress notes in Medecare were reviewed for the resident involved on the date of the incident and documentation indicated the missing controlled substance, a search was completed and it was not found. No documentation was found related to assessment of the resident, actions taken, notification of resident, family, physician, pharmacy or Director of Care.

The Roulston's "Medication Incident Reporting" policy #14:7 was reviewed and stated:
- Every medication incident involving a resident and every adverse drug reaction is, documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and reported to the resident, the resident's substitute decision maker, if any, the director of nursing and personal care, the medical director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.
- In addition, the home ensures that, (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; (b) corrective action is taken as necessary; and (c) a written record is kept of everything under clauses (a) and (b).

The licensee has failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health; reported to the resident, the resident's substitute decision-maker, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, reviewed and analyzed; corrective action taken as necessary; and a written record kept for a medication incident involving a missing controlled substance. [s. 135.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the resident's health; reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, reviewed and analyzed; corrective action taken as necessary; and a written record kept, to be implemented voluntarily.

WN #7: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

A Critical Incident was submitted by the licensee on an identified date related to a

resident who sustained a fall and subsequent injury.

The resident health records were reviewed in Medecare. The care plan stated under Bed Mobility, that quarter repositional bed rails were to be elevated and in place when resident was in bed. Under Restraints/Safety Devices, it stated that bed rails were to be elevated and in place when resident was in bed. Under Transferring, it stated that bed rails were to be used for bed mobility or transfer.

The resident's paper chart was also reviewed. There were two Bed Rail Risk Assessments found, one with a date identified, indicating an annual assessment and recommendations to use two quarter repositional rails, care plan updated indicated "yes". The other assessment was not signed or dated, did not indicate the type of assessment, indicated recommendations to use assist rails, did not indicate how many rails to be used, and care plan updated indicated "no"

The resident's room was observed by inspector #741, #745 and #213 and noted that no bed rails were in place on the resident's bed.

In an interview with a registered nursing staff, they said that this resident did not have bed rails on their bed and that the care plan was not up to date.

In an interview with another registered staff, they stated that the notes documented in the care plan regarding bed rails were entered by them. The registered staff reported that the resident's care needs had since changed and no longer used bed rails. When questioned about the direction to use bed rails in the care plan, they said that the care plan was not up to date.

The resident's care plan included a note on a specific date that resident was to be assisted into a specific chair if not settling in their bed at specific times to recline, and brought out to the nursing station for closer observation. Another note in the care plan with the same date stated that an order and consent had been received for a new tilt wheelchair.

Progress notes documented in Medecare on a specific date stated that the resident could be assisted into the specific chair when unable to settle at another specific time, and placed into the specific chair at a specific time to be reclined and brought to the nursing station for closer observation. 22 days later, a progress note documented by the same registered staff, stated that the resident had a new tilt wheelchair.

The resident was observed sitting in a tilt wheelchair on two different days.

A registered staff member said they charted the notes in the care plan regarding the resident's use of a specific chair at specified times. The registered staff member stated that the resident's care needs changed 22 days later when the resident's family brought in a new tilt wheelchair to use instead of the specific chair. The registered staff reported that they documented notes in the care plan without reviewing the care plan first and deleting old notes that no longer reflected the resident's current care needs. The registered staff stated that they failed to review and update the care plan when the resident's care needs changed.

The licensee has failed to ensure that a resident was reassessed and the care plan was reviewed and revised when the resident's care needs changed related to the use of bed rails and the use of a specific chair at specific times. [s. 6. (10) (b)]

WN #8: The Licensee has failed to comply 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. O. Reg. 79/10, s. 100.

Findings/Faits saillants :

1. The licensee has failed to ensure that the written procedures required under section 21 of the Act incorporated the requirements set out in section 101.

The home's complaint binder was reviewed and the Inspector found the following: A Family/Client Satisfaction Log contained seven complaints dating from February 2016 and the last one on the list dated July 18, 2017. There was no documentation of any review or analysis of complaints for trends or improvements needed.

When asked if complaints were reviewed and analyzed quarterly for trends and improvements needed, Director of Care said no.

When asked if complaints were reviewed and analyzed quarterly for trends and improvements needed, Administrator said no. When asked who's responsibility it was to review the complaints policy, they said it was them. When asked if the home's complaints policy was reviewed since 2011, they said no.

The home's "Resident Complaints/Concerns" policy #ADM-II-332 was reviewed. The policy was dated June 1, 2011 and indicated "Document the information on a Complaint Record". The home's policy did not indicate that the documented record is to be reviewed and analyzed for trends at least quarterly; the results of the review and analysis taken into account in determining what improvements are required in the home; and a written record kept of each review and of the improvements made in response.

The licensee has failed to ensure that the written procedures required under section 21 of the Act incorporated the requirements set out in section 101 including reviewing and analyzing the documented record of complaints at least quarterly, the results of the review taken into account in determining what improvements are required in the home and a written record kept of each review and of the improvements made in response. [s. 100.]

WN #9: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

The home reported a Critical Incident on an identified date related to a medication incident that occurred the previous day whereby a resident received the medications prescribed for another resident and required treatment.

The home's medication incidents were reviewed and found that a Medication Incident Report was completed whereby a registered staff member administered another resident's medications to the wrong resident.

The electronic Medication Administration Record (eMAR) was reviewed for the resident identified in the incident and showed that the resident's usual medications to be administered the day that the incident occurred were held.

The resident was interviewed and said that they remembered being given another resident's medications the week prior and needing treatment.

The registered staff member involved in the incident was interviewed and remembered the incident where they gave the resident another resident's medications. They said it was an unintentional error, and was noticed immediately and reported immediately to the charge nurse. They said that the resident was monitored related to the medications that they received and treatment was provided.

The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident when resident was given the medications prescribed for another resident and required treatment. [s. 131. (1)]

Issued on this 3 rd day of January, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by RHONDA KUKOLY (213) - (A1)
Inspection No. / No de l'inspection :	2018_605213_0022 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	004767-18, 005643-18, 006828-18, 007310-18, 007753-18, 010785-18, 010788-18, 010805-18, 016402-18, 016787-18, 017003-18, 017004-18, 024983-18, 029244-18 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 03, 2019(A1)
Licensee / Titulaire de permis :	Maplewood Nursing Home Limited 73 Bidwell Street, TILLSONBURG, ON, N4G-3T8
LTC Home / Foyer de SLD :	Maple Manor Nursing Home 73 Bidwell Street, TILLSONBURG, ON, N4G-3T8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marlene Van Ham

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To Maplewood Nursing Home Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_607523_0013, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee must be compliant with s.15(1)(a).

Specifically the licensee must:
1. Ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.
2. Review and evaluate the Bed Rail Risk Assessment tool and revise as necessary.
3. Review and evaluate the Bed System Measurement Device Test Results Worksheet tool and revise as necessary.
4. Develop and implement a tool and process for tracking and documenting resident bed rail use assessments and bed system risk for entrapment assessments including the dates when assessments were completed, room number, bed number, mattress number, presence of bed rails and results, to ensure information is housed in one document that is accurate and current at all times.
5. Ensure all registered staff are retrained to assess residents related to bed rails and evaluate their bed system and all other staff responsible to evaluate bed systems in the home, in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident. Training must include the use of current assessment tools in the home and documentation required including the tracking tool.
6. Ensure that this training is also incorporated into the home's orientation process for new registered staff and any other staff with responsibility for assessment of residents related to bed rails and/or evaluation of their bed system.
7. Develop and implement a process for tracking staff training including the dates when training was completed by staff, to ensure training is completed by all registered staff, and documented.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, the resident was reassessed and his or her bed system evaluated in accordance with evidenced-based practices, and if there were none, in accordance with prevailing practices to minimize the risk to the resident.

Compliance Order #002 was issued during inspection #2018_607523_0013 on July 12, 2018 to comply with LTCHA 2010, s. 15(1)(a) with a compliance date of August 31, 2018. Specifically, the licensee was ordered to:
a) Ensure that where bed rails are used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.
b) Ensure that all registered staff are trained to assess residents and evaluate their bed system in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

a) The policy "Resident Bed Rail Assessment Risk for Entrapment", dated June 30, 2018, was reviewed. It stated that prior to assessing a resident for use of assist rails, a bed entrapment assessment must be conducted with the rails in place. An evaluation tool for the use of bedrails was also to be used to determine the capability of a resident using assist rails.

The Director of Care (DOC) said the home contracted an external company to assess and evaluate the beds in their facility for entrapment. The assessors compiled a Facility Entrapment Report, which documented whether bed rails were in place, the type of rails, bed frame, mattress and zones of entrapment in 96 beds in the facility.

A random sample of 10 beds was chosen from the Facility Entrapment Report and Inspectors #213 and #741 observed if the bed frame, bed rails, and mattress listed in the report corresponded with the beds in the rooms. The following observations were made:
- An identified bed in an identified room was listed on the report to have no bed rails and a specific mattress, and it was found that the bed in that room was a different bed, with bed rails in place and a different mattress.
- Another identified bed in a second room was listed on the report to have no bed rails and a specific mattress, and it was found that the bed in that room was a different bed, with bed rails in place and a different mattress.
- Another identified bed in a third room was listed on the report to have no bed rails and a specific mattress, this was found to be in place during the observation

A record review of the "Bed Rail Risk Assessment" and plan of care for the resident who resided in the third room, was completed. There were two Bed Rail Risk Assessments found for a resident, one with a specified date indicating an annual

assessment and recommendations to use two quarter repositional rails, care plan updated indicated "yes". The other assessment was not signed or dated, did not indicate the type of assessment, indicated recommendations to use assist rails, did not indicate how many rails to be used, and care plan updated indicated "no".

One staff member, who had received training for assessing beds for entrapment, said that when there was a new admission, a resident returned from hospital or there was a change in the bed system, they or the other staff member also trained for assessing beds, completed a "Bed System Measurement Device Test Results Worksheet". They said that the bed system was assessed using a tool to test for risk of entrapment and the worksheet was completed and given to the DOC. The staff member said that they did not update the "Facility Entrapment Report" at any time.

Inspector #213 and #741 asked the staff member about the discrepancies with the documentation and observations for the beds in the two rooms. The staff member stated that the bed in the first room was not the bed listed on the report. The staff member said that the bed in the second room was assessed using the "Bed System Measurement Device Test Results Worksheet".

The DOC provided a binder of "Bed System Measurement Device Test Results Worksheet" sheets. Included in the binder was a sheet with a specific date indicating the bed had bed rails in use that passed all zones. There was a print out of an email from SFI Medical to the home with a specific date indicating one bed in an identified room required troubleshooting and repair. There was no worksheet for this bed. The second bed was noted to be listed on the "Facility Entrapment Report" in a different room.

Also in the binder of bed system measurement worksheets, the following worksheets were found with missing information:
- One identified room no bed number indicated
- One identified a bed number, no room number indicated
- Another identified a bed number, no room number indicated

In an interview with the DOC, they stated that the bed in the first room likely been replaced with a new bed. The DOC reviewed the Facility Entrapment Report with the inspectors #213 and #741 and stated that it was not up to date. The DOC was not able to find a bed system measurement worksheet for the first bed that was being

used by an identified resident and said there should have been an assessment completed for that bed and that resident.

b) In an interview with the DOC related to the staff training required in the order, the DOC stated that bed entrapment was reviewed with registered staff in June 2018 and that the full training was provided to registered staff in October 2018.

The sign in sheet titled "Education Bed Rail Entrapment Side Rail Assessment 2018" was reviewed by Inspectors #213 and #741 and it showed signatures of completion for nine out of twenty registered staff with dates ranging from June 26 to July 19, 2018.

The sign in sheet titled "Inservice Maple Manor LTC Bed entrapment Review and Side Rail Evaluations, Continence Care and Bowel Management Program, Policy NDM-111-240 Nursing Manual, Perineal Care, Pharmacy: Opiods and Overdose Naloxone Education, October 17, 2018" was reviewed by Inspectors #213 and #741. The sheet included 11 registered staff names. The registered staff schedules were reviewed and noted that there were 24 registered staff (Registered Nurses and Registered Practical Nurses) working in the home. The DOC stated that not all of the registered staff received the training by the compliance order date of August 31, 2018 or by the date of the follow-up inspection.

The licensee has failed to ensure that where bed rails were used, the resident was reassessed and his or her bed system evaluated in accordance with evidenced-based practices, and if there were none, in accordance with prevailing practices to minimize the risk to the resident for two identified beds and one identified resident. In addition, documentation bed system evaluation was unclear and not up to date.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 1 as it related to two of the ten beds or residents reviewed. The home had a level 3 compliance history as they had one or more non-compliance in the last 36 months with this section of the Long-Term Care Homes Act that included:
- Compliance Order #002 issued July 5, 2018 (2018_607523_0013). (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2019(A1)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. Nursing and personal support services

Order / Ordre :

The licensee must be compliant with s. 31 of O. Reg 79/10.

Specifically, the licensee shall ensure the following:
a) Ensure that residents #009, #010, #011, #012, #021, and all other residents, are bathed at a minimum twice a week by the method of their choice and bathing is documented.
b) Develop and implement an auditing process to ensure that all residents are bathed at a minimum twice a week by the method of their choice. Records for these audits are to be maintained.
c) Evaluate and update the home's staffing plan in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. The evaluation must be documented including the names of the persons who participated in the evaluation, a summary of the changes made and the date the changes were implemented.
d) Develop and implement a back-up plan for nursing and personal care staff that addresses situations when staff cannot come in to work, including how baths will be completed, by whom and when. The back-up plan must be documented and communicated to all staff.
e) Communicate the staffing plan evaluation and back-up plan with the Resident's Council and Family Council and document the communication in the Council minutes.

Grounds / Motifs :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and the Regulation.

The Ministry of Health and Long Term Care received three anonymous complaints between April and September 2018 related to concerns about the home being short staffed and baths not being provided.

The "Scheduling of Staff Nursing Department" policy with a revised date of March 2018, was reviewed and stated: The departments staffing plan and staff schedules based on the departmental budget allocation, and regular schedules where all shifts are covered by qualified facility staff in accordance with provisions in the collective agreement requirements under the Long Term Care Homes Act (LTCHA), Ontario Regulation 79/10 section 31(3), resident safety criteria and the efficient and effective operation of the home.

The "Guidelines for Calling Relief" policy with a revised date of October 30, 2018, was reviewed and stated:
- Supervisory staff shall endeavor to maintain a full complement of staff each shift in accordance with the authorized staffing pattern.

The "Shortage of Staff" policy with a revised date of April 2018, was reviewed and stated:
- The overall concern is to maintain staff and Residents Health and Safety. When staffing level is not complimented to fullest, each floor will be rotated as when staff is working short. Therefore when one floor works short one day, the second floor will work short the next time. The alternating of floors will prohibit the same staff form working short on a regular basis and decrease the likelihood of injury.
- Registered staff is responsible to ensure this delegation is issued at the time of shift change when this is effective. The least seniority staff member either full-time or part-time will be the staff member to change floors if deemed necessary.

The "Shift Routine" and "Contingency Plans was reviewed and included the following as the home's staffing plan:
Day shift on each floor for first and second floor:
Registered Nurse (RN) – 1
Registered Practical Nurse (RPN) – 1
Personal Support Worker (PSW) – 5
Tub Person - 1
Floats – 2
Evenings on each floor for first and second floor:

RN-1
RPN-1
PSW-4
Float-1
Nights on each floor on first and second floor:
RN-1
PSW-4

A review of the home's staffing schedule for PSWs from August 1, 2018 to November 18, 2018 identified a lack of full staffing complement on a daily basis for PSWs. The home was not able to locate the paper schedules for first floor for the period of October 19 to 25, 2018 or for second floor for the period of October 22 to 28, 2018.
A review of the first floor PSW schedule from October 1, 2018 to November 18, 2018 showed 37 out of 42 days, the unit was short one to four PSWs.
A review of the second floor PSW schedule from October 1, 2018 to November 18, 2018 showed 39 out of 42 days, the unit was short one to four PSWs.

Inspector #745 requested the home's contingency plan for when staff were not able to come to work. The Director of Care (DOC) provided a document labeled "Contingency Plan". It was reviewed and indicated direction and routines as follows:
DAYS:
- Each floor full complement of PSW staffing are:
Five PSWs start time 0600 hours to 1400 hours
One PSW start time 0615 hours to 1415 hours
Day Float PSW start time 0700 hours to 1300 hours
Day Tub Bath start time 0600 hours to 1300 hours
- Met with full time PSW's Oct 30, 2018 and discussed changing the number of residents in their charge from six groups to five groups and having the sixth PSW as a float who will attend to residents from each of the five groups.
- As full complement of staffing have been reduced to 5 instead of 6 due to staffing issues.
- PSWs work in a team to coordinate assistance from each other when needed instead of trying to find a co-worker for assistance.
- Morning breaks remain at 15 minutes, lunch breaks have changed to 45 minutes. Leaving three PSW's on the floor at a time.
- Residents two tub baths per week have been changed to two day tub baths. Evening tub baths are no longer due to lack of staffing.

- The PSW who is scheduled from 0615 hours to 1415 hours answer call bells and continue with incidental rounds while during the afternoon shift report.

EVENINGS:
- Each floor Full Complement of PSW staffing are:
Registered Staff assist in the dining rooms during supper on both floors
Four PSWs start time 1400 hours to 2200 hours
One PSW start time 1415 hours 2215 hours
- 2215 PSW will do rounding and answer call bells during the night report
- PSWs will assist residents with the nourishment cart and record intake
- One PSW will complete the remainder of baths between 1400 hours and 1700 hours
- PSWs will assist residents getting up from afternoon nap
- Breaks have been changed to two 30 minute breaks
- PSWs team up after supper and assist residents with their needs

NIGHTS:
- Full complement of PSW staffing are:
Four PSWs start time 2200 hours to 0600 hours
One PSW start time 2215 hours to 0615 hours
- The 0615 PSW answer call bells while days are in report
- PSWs start their rounds work in pairs

A review of the Medical Advisory Committee minutes for Sept 20, 2018 showed:
New Business:
Staffing crisis: shortage of PSWs. PSWs have been working 12 hour shifts. Tub bath personnel have been pulled to work on the floor. Many overtime hours have been established. Interviews conducted, potential employees do not show up for either interviews or orientation.
Job postings have been placed on Indeed for a fee. Numerous applications have been reviewed and interviews set up. Potentially by end of October all positions will be filled and with casual employees.

Inspector #745 reviewed weekly bath schedules for both first and second floor and noted the following:
Created by bath PSW and then administration staff update
Organized by days of the week, resident room numbers and names

Average of 16 to 18 baths per day per floor

The staff schedules for each floor were reviewed for the bath shifts for the period of October 1 to November 18, 2018. The home was not able to locate the paper schedules for first floor for the period of October 19 to 25, 2018 or for second floor for the period of October 22 to 28, 2018. The schedules showed:
- First floor: 17 out of 63 scheduled shifts had no bath staff scheduled or worked.
- Second floor: 33 out of 70 scheduled shifts had no bath staff scheduled or worked.

In an interview with a staff member by Inspector #745, when asked about staffing, they said the home was staffed well for registered staff, but there was definitely a problem for PSWs, they were constantly short and moving people around. Baths were unable to be done many days because it was the bath person who was sick. The staff member pointed to the shift schedule indicating one staff should be assigned a specific line responsible for tub baths from 0600 hours to 1300 hours each day on each floor. The staff member demonstrated that for the schedule from November 5 to 18, 2018 for second floor, seven out of fourteen days had "Tub Bath" staff filled in. When asked who handled staffing issues on each shift, they said administration staff, if during regular hours and registered staff after hours.

In an interview by Inspector #745, with a staff member, they explained that when a sick call was received, they would start making calls based on seniority. They would make verbal calls, or send out texts until they had exhausted the list. When asked who authorized overtime, they said the DOC if there, if not there then registered staff would get authorization to offer overtime.

In an interview with another staff member, by Inspector #745, they said staffing was bad and they were short staffed PSWs every day and every shift. They said staff were asked to stay longer, do 12 hour shifts instead of 8 hours and they offered overtime or people wouldn't stay. Vacation has been denied but then that made things worse and people just called in sick. When asked if care was affected because of short staffing, they said that they cut corners in personal care and baths didn't get done, as they rarely had a tub person. When asked what the expectation was if baths were not done, they responded there really was no direction, each PSW did what they could, bed bath, no bath, hands and face only.

In an interview with another staff member, by Inspector #745, they said sick calls

were constant and staff were frustrated. They said evening shift was worse, family and residents complained but they just did the best they could. When asked how care was affected, they answered they didn't get their care done, they cut corners, baths weren't done as bath staff was pulled.

In an interview with another staff member by Inspector #745, they said they were responsible for creating the tub schedule and all residents who requested a tub bath were on the list for a bath twice a week. When asked what happened when short staffed, they answered if they were short four PSWs on a floor, the baths were cancelled as per the DOC, and that many days no one was even booked to complete baths. When asked who documented if baths were completed or not, they were unsure who did that. The staff member said that they stayed late a lot of days to get baths done, but couldn't all of the time. They also said second floor was worse, most days they have had no bath nurse.

In an interview with another staff member, by Inspector #745, they said they had a tub person, but the tub person was on modified duties and were not doing any baths at that time. They have been replaced but the new staff never came in, so they have been short many days. When asked what happens then if there was no bath staff, they responded that they did as many baths as they could on days and then the registered staff pass on what residents needed a bath on evenings, but that was impossible as they were also short on evenings.

In an interview with a resident by Inspector #745, when asked about baths, they said they were supposed to have two baths per week. They said they have missed four baths in the last two weeks; they've missed a lot of baths. A review of bathing documentation for this resident in Medecare showed they missed three out of four scheduled baths in a two week period.

In an interview with another resident, by Inspector #745, when asked about baths, they said they have missed so many baths they recently stopped counting at nine. They said they were supposed to have two baths per week. They said they missed lots of baths, they just get no bath, no communication at all. They said they were worried about getting an infection because of not getting baths. The resident said they enjoyed their baths, they liked to soak, but there was no time for that. The resident said that the bath nurse quit last week, that's why they didn't get their bath that day. A review of the bathing documentation for this resident in Medecare

showed they missed three out of four scheduled baths in a two week period.

In an interview with another resident, by Inspector #745, when asked about baths, they said they didn't get anything in place of missing a bath. The resident was unsure of their usual bath day, but said a lot got missed. A review of bathing documentation for this resident in Medecare showed they missed two out of four baths in a two week period.

In an interview with another resident, by Inspector #745, when asked about baths, they said they were supposed to have two baths per week, and they were not sure when they last had a bath. They said they didn't think they have had many recently. The resident said they would ask the staff each day if they were going to get a bath and the answer was no, they were short staffed again. A review of bathing documentation for this resident in Medecare showed they missed two out of four scheduled baths in a two week period.

In an interview with another resident, the resident was not able to recall their bath schedule, when they had last had a bath or if baths had been missed. A review of bathing documentation for this resident in Medecare showed they missed three out of four scheduled baths in a two week period.

In an interview with Director of Care by Inspector #745 regarding staffing, they said that they have had retirements, medical leaves and maternity leaves. They said the schedule would be put out two months in advance, and then people went off, they have been unable to replace them, specifically PSWs. When asked about cancelling baths, they answered if they didn't have the staff then they didn't do them, they were not sure what else to do. When asked if they were actively recruiting staff, they answered yes, they have been doing three to five PSW interviews per week, but they had people not show up for their interviews or they hired them and then they didn't come to orientation, or they started and quit. They said that they have posted jobs on Indeed and they went to a Tillsonburg job fair. When asked who authorized overtime, they said they did, the staff would call them on weekends and during the night to get authorization. When asked if they had a written staffing evaluation, they answered no, they didn't have that written. When asked how they knew baths weren't getting done, they said they knew the numbers were really high for baths not being done. The Inspector demonstrated on second floor, the bath shifts that were not filled on the schedule, and asked if the staffing plan met the assessed needs of residents and

provided for them being bathed a minimum of twice a week, they said they'd have to say no. The Inspector asked about Medical Advisory Committee minutes, under new business indicating potentially by the end of October, all positions filled, they answered that they thought they had lots of applicants, but it hasn't worked. When asked if there was a plan to address the staffing shortages, they answered December 13, 2018 is the next Medical Advisory Committee meeting where it will be discussed again.

The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and the Regulation including when five residents were not bathed at a minimum twice a week by the method of their choice as a result of the home not being fully staffed as per their staffing plan.

The licensee also failed to have a back-up plan for nursing and personal care staffing that addressed situations when staff could come to work. The licensee also failed to keep a written record relating to each annual evaluation of the staffing plan in accordance with evidence based practices that included the date of the evaluation, the names of the persons who participated, a summary of the changes made and the date that those changes were implemented.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 3 as it related to five of the five incidents reviewed. The home had a level 2 compliance history as they had one or more unrelated non-compliance with this section of the Long-Term Care Homes Act in the last 36 months.
(213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2018_607523_0013, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s.107.

Specifically the licensee must:
1. Develop and implement a policy and procedure related to reporting to the Director, including required time frames, responsibilities, etc. Refer to the Ministry of Health and Long-Term Care Long Term Care Homes Portal; the November 2, 2018 Reporting Requirements Tip Sheet and the Reporting Requirement Amended Memo August 31, 2018 from the Director as a guide to develop the policy.

2. Ensure all registered staff including the Director of Care and the Administrator receive training in reporting requirements including critical incidents, mandatory reports and the home's policy for reporting to the Director.
3. Develop and implement a process for tracking staff training including the dates when training was completed by staff, to ensure training is completed by all registered staff, and documented. Ensure that this training is also incorporated into the home's orientation process for new registered staff.

Grounds / Motifs :

1. The licensee has failed to ensure that the Director was informed of a missing or unaccounted for controlled substance in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

The quarterly medication incidents review in the Medical Advisory Committee meeting minutes for the period of June, July and August 2018, was reviewed. The errors listed in the review included a missing controlled substance.

The Medication Incidents binder was reviewed and no medication incident was found related to a missing controlled substance.

The Ministry of Health and Long-Term Care (MOHLTC) Critical Incident System (CIS) was reviewed and there were no missing or unaccounted for controlled substances reported by the home in 2018.

The Director of Care (DOC) said that they could not find the medication incident related to the missing controlled substance, could not recall that incident and contacted the pharmacy. Pharmacy faxed a copy of the report to the home. The form was reviewed with the DOC and the Inspector and it indicated a missing controlled substance. When asked if the missing controlled substance was reported to the MOHLTC, the DOC said no.

Compliance Order #001 was issued on July 12, 2018 in inspection #2018_607523_0013 that stated: "The licensee must be compliant with s. 107(1)(2). Specifically the licensee must ensure that the Director is immediately informed, in as much detail as possible in the circumstances, of an unexpected death, including a death resulting from an accident or suicide". The compliance date for this order was August 31, 2018.

In an interview with the Administrator, when asked if there have been any sudden or unexpected deaths since the order was served, the Administrator said no. When asked what the home did to comply the order, the Administrator said that they posted "Appendix A: Table 1: LTCHA Subsection 24(1) – Reporting Certain Matters to the Director" and "Appendix B: Table 2: Critical Incident Reporting under O Reg 79/10 subsections 107(1), (3.1), and (7)" in the nursing stations, along with a sheet titled "Clarification of Mandatory and Critical Incident Reporting Requirements".

The Administrator provided two sheets titled "Clarification of Mandatory and Critical Incident Reporting Requirements". There were nine registered staff signatures on one sheet and nine registered staff on the other sheet. The registered staff schedules were reviewed and noted that there were 24 registered staff (Registered Nurses and

Registered Practical Nurses) working in the home.

Inspector #213 asked the Director of care (DOC) if there was any direction provided to staff to review the two tables of reporting requirements and sign that they have read and understood or if they were aware that it was their responsibility to call the after-hours line to report a sudden or unexpected death. The DOC said that the Administrator was responsible for the follow up to the compliance order related to reporting to the Director, they weren't sure what was done or not done related to that compliance order. When asked if there had been any sudden or unexpected deaths in the home since July 2018, the DOC said no.

When asked if there was any direction provided to staff to review the two tables of reporting requirements and sign that they have read and understood, the Administrator said no. When asked if that could be the reason why only 18 out of 24 staff signed the sheets, the Administrator said they couldn't say why all of the staff didn't sign the sheets. When asked if anyone followed to up ensure that all registered staff signed the sheets and were aware of their responsibility to call the after-hours line if there is an unexpected death, the Administrator said no, they didn't. When asked if there was any direction provided to registered staff that it was their responsibility to call the after-hours line for the MOHLTC if there was an unexpected death, the Administrator said no.

The licensee has failed to ensure that the Director was informed of a missing controlled substance no later than one business day after the occurrence of the incident, followed by the report required under subsection (4). The licensee also failed to take appropriate actions related to Compliance Order #001 issued in Inspection #2018_607523_0013 related to immediately reporting a sudden or unexpected death to the Director.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 1 as it related to two of the twelve incidents reviewed. The home had a level 4 compliance history as they had on-going non-compliance with this section of the Long-Term Care Homes Act in the last 36 months that included:
- Voluntary Plan of Correction (VPC) issued March 24, 2016 (2016_277538_0003);
- VPC issued March 5, 2018 (2018_678680_0005);
- Compliance Order #001 issued July 5, 2018 (2018_607523_0013). (213)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Jan 18, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 3 rd day of January, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by RHONDA KUKOLY (213) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

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