Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 23, 2015	2015_302600_0012	T-1755-15	Resident Quality Inspection

Licensee/Titulaire de permis

ROYAL CANADIAN LEGION DISTRICT 'D' CARE CENTRES
59 Lawson Rd TORONTO ON M1C 2J1

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

TONY STACEY CENTRE FOR VETERANS' CARE
59 Lawson Road TORONTO ON M1C 2J1

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

GORDANA KRSTEVSKA (600), JOANNE ZAHUR (589), SUSAN SEMEREDY (501), TILDA HUI (512)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, 19, 22, and 23, 2015.

The following follow up, critical incidents and complaints were inspected concurrently: T-1450-14, T-2360-15, T-1546-14, T-1240-14, T-2384-15, T-2459-15, T-2281-15, T-2203-15, T-2673-15,T-2674-15 and T-2690-15.

During the course of the inspection, the inspector(s) spoke with the executive director (ED), associate executive director (AED), director of care (DOC), nurse managers, registered dietitian (RD), dietary supervisor (DS), environmental manager (EM), Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinators, physiotherapist (PT), Resident Council president, social worker, registered staff, personal support workers (PSWs), activity aides, residents, substitute decision makers (SDMs) and family members.

During the course of the inspection, the inspector(s)conducted a tour of the home, observed meal service, medication administration system, staff and resident interactions and the provision of care, and reviewed health records, complaint and critical incident record logs, staff training records, meeting minutes for Residents' Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **32 WN(s)**
- **20 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 76. (2)	CO #002	2014_321501_0016	501

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. This section of the LTHCA, 2007 s.76.(4) was issued as an order #003 as part of the Resident Quality Inspection (RQI) #2014_321501_0016 report dated November 26, 2014.

Due to the risk to residents, the scope of the non-compliance as well as the above mentioned previous order, the following has been reissued:

The licensee has failed to ensure that all staff receive retraining annually related to the Residents' Bill of Rights; zero tolerance of abuse and neglect; mandatory reporting under section 24 and the whistle-blowing protections afforded by section 26.

Review of staff training records for 2014/2015 indicated 69 per cent of staff did not receive retraining related to the zero tolerance of abuse and neglect. There was no evidence that any staff received retraining related to the Residents' Bill of Rights, mandatory reporting under section 24 and the whistle-blowing protections afforded by section 26.

Interview with staff # 129 and ED confirmed staff were not provided with retraining for the above mentioned areas and the numbers presented in the training record were correct. [s. 76. (4)]

2. The licensee has failed to ensure that direct care staff are provided with training on how to minimize the restraining of residents and how to restrain residents in accordance with the requirements for restraining that are set out in the Act and Regulations.

Review of the home's training records revealed that 75 per cent of direct care staff had not received restraint related training in the past 12 months.

Interview with the DOC confirmed that 75 per cent of direct care staff did not receive the required training on how to minimize the restraining of residents in accordance with the requirements that are set out in the Act and Regulations. [s. 76. (7) 4.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. This section of the O.Reg. 79/10, s.30(1) was issued as order #001 as part of the Resident Quality Inspection (RQI) #2014_321501_0016 report dated November 26, 2014.

Due to the risk to residents, the overarching scope of the noncompliance as well as the above mentioned previous order, the following is being reissued:

The licensee has failed to ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation.

There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Interview with the ED, AED and DOC revealed that none of the programs that were identified in the compliance order from last year's RQI had not been updated to include:
• Goals and objectives,
• Relevant policies, procedures and protocols,
• Methods to reduce risk and monitor outcome, including protocols for the referral of residents to specialized resources.
The managers stated that even though they have created a policy, form and schedule to evaluate programs annually, no evaluations have yet to be completed and the programs have not been updated.

Programs identified during this inspection as not meeting this requirement include:

HYDRATION
The legislation, LTCA 2007, c.8, s.11 (1)(a) requires that there is an organized program of hydration for the home to meet the hydration needs of residents.

Inspector #501 asked the DOC for the home's policy regarding hydration in relation to an intake being completed during the Resident Quality Inspection (RQI) and received two different policies. Review of these policies revealed the following:
1. Maintaining Proper Hydration dated May 1, 2015:
• This policy had an opening section that refers to a resident's food intake but does not include fluid intake.
• The opening sentence also refers to a three day food intake monitoring record to be implemented for the dietitian to review for residents with significant change. There was no description of what significant change is.
• The policy and procedure goes on to describe dietary's role in assessing a resident's nutritional status and there was no indication what nursing's role is or how the interdisciplinary team works together.
• The procedure stated that measures shall be taken to identify and address those at high nutritional risk or at risk of dehydration but does not describe the measures that are to be taken.
• The policy then describes risks related to nutrition and or hydration but does not include methods to reduce these risks or monitor outcomes and when to refer to resources such

as the dietitian.
• The rest of the policy includes mealtime assistance addressing positioning, staffing levels and assisting residents.
• The policy then ends with a statement that the program of nutritional care shall be evaluated annually for effectiveness.

2. Hydration Management (hypodermoclysis) dated January 12, 2013:
• There was no mention of hypodermoclysis in this policy even though the title indicates this is included.
• There was a list of classic signs and symptoms as an initial assessment for dehydration but does not include any strategies or interventions to address dehydration should that be diagnosed.
• The policy stated to monitor resident's hydration status based on dehydration risk assessment checklist but there is no checklist included.
• There is no mention of referring to specialized resources.

Interview with the ED, AED and DOC confirmed that this hydration program does not meet the requirements as listed in the Regulation.

RECREATION AND SOCIAL ACTIVITIES
The legislation, LTCHA 2007, c.8, s. 10(1), requires that there is an organized program of recreational and social activities for the home to meet the interests of the residents.

Inspector #600 found that resident #009, #011 and #015's activity patterns and pursuits were not being reassessed and their plans of care reviewed at times when their care needs changed.

Interviews with activation staff #125 and #126 revealed that the department did not have a lead for several months. Interview with the ED confirmed that there was no lead for this department from February of this year to June 22, 2015, and could not provide any relevant policies, procedures or protocols to guide staff in the interim.

DIETARY SERVICES
The legislation, LTCA 2007, c.8, s.11 (1), requires that there is an organized program of nutrition care and dietary services for the home to meet the daily needs of residents.

Inspector #501 found that significant weight change for resident #006 was not assessed by an interdisciplinary team. Review of the home's policy titled Weight Changes dated

January 1, 2011, stated that if a resident has significant weight change, the charge nurse is to refer the resident to the dietitian for further assessment. Interview with the RD revealed that she does not always get referrals for weight change, often checks the weight books for changes and there are times when changes get missed. Interview with the DOC revealed that once weight change is identified, the registered staff start monitoring the resident's intake more closely and refer to the RD. There is no indication in the policy that registered staff are to do anything but refer to the dietitian. In addition, the policy states that if the body weight value appears to be incorrect i.e. great variance from previous weights, then the charge nurse will have the resident reweighed. There is no indication what constitutes great variance for reweighs so that referrals to the RD may be made for those residents that were simply weighed incorrectly.

Interview with the DOC confirmed that the policy for weight change does not provide methods to reduce risk and monitor outcomes and the RD confirmed that protocols for the referral of weight changes are not consistent. The ED confirmed that the home does not have a nutrition care and dietary services program to meet the needs of residents.

ACCOMMODATION SERVICES
The legislation, LTCA 2007, c.8, s. 15(1), requires that there is an organized program of housekeeping for the home.

Review of the housekeeping policy revealed there is no description regarding specific procedures for the cleaning of resident bedrooms, common and staff areas. There is no procedure for cleaning and disinfecting resident care equipment, the safe removal of wet and dry garbage or procedures to address lingering offensive odours. The AED confirmed that this policy does not meet the requirement to reduce risk and monitor outcomes and indicates that the home lacks an organized program of housekeeping.

SKIN AND WOUND CARE PROGRAM
The legislation, O.Reg. 79/10, s.48(1)(2), requires that there is a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

Review of the home's policy titled Skin and Wound Management and Prevention dated August 17, 2014, revealed that a skin assessment is done on all residents regularly on bath days. In another section of the policy it states that PSWs are to complete skin assessments with every other bath monthly and report altered skin integrity immediately to registered staff. Inspector #600 found that the recording of skin being intact or not by

PSWs was not reported for period of August, September, October 2014 and June 16 – 30, 2015.

Review of the home's policy revealed there is no definition for altered skin integrity and only addresses stages of pressure ulcers. As per the O.Reg 79/10, s.50(3) "altered skin integrity" means potential or actual disruption of epidermal or dermal tissue. In s.50(2)(b) altered skin integrity includes skin breakdown, pressure ulcers, skin tears or wounds. Inspector #512 found that there were no skin assessments for skin rashes and that residents were not always assessed by a registered dietitian. It was found that the practice of the home is to make a referral to the RD only with stage II or greater pressure ulcers. Review of the home's policy states that registered staff are to send a referral to the RD immediately when a resident exhibits altered skin integrity however since the policy does not define altered skin integrity this is open to interpretation. To further confuse staff, the policy includes a form to the dietitian that includes "decubitus ulcers" as an indicator to check for referral but nothing for "altered skin integrity".

Interview with managers confirmed that the skin and wound care program does not provide methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources, including the RD.

During the course of this inspection, inspector #501 had conversations with the ED regarding the lack of organized programs. The ED confirmed that this had to become a priority as there were many negative outcomes for residents as evidenced by the number of findings of noncompliance found during this inspection. [s. 30. (1) 1.]

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. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. Due to the serious risk for residents the following is being issued as an order:

The licensee has failed to ensure that the hydration program includes the development and implementation of policies and procedures relating to hydration in consultation with a dietitian who is a member of the staff.

Review of the home's policy titled Maintaining Proper Hydration dated May 1, 2015, indicated that a three day food intake monitoring record will be implemented for the dietitian to review for residents with significant change and a referral is to be sent for further assessment. There is no indication what constitutes significant change and when exactly referrals are to be sent. Another policy titled Hydration Management dated January 12, 2013, indicated that staff should observe and monitor for classic signs and symptoms of dehydration, assess these signs and symptoms, monitor hydration status, develop interventions to address hydration as needed, encourage resident and family participation and evaluate and document resident outcome and update the care plan. There is no indication exactly what interventions staff are to take or specific protocols to follow.

Record review revealed that resident #020 was admitted to the home on a specified date and was sent to the hospital where he/she passed away. Record review and interview with family member #202 revealed the resident was sent to the hospital due to poor intake of food and fluids and was diagnosed with an identified health condition.

Review of resident #020's progress notes revealed that a family member was concerned that the resident had an identified health condition on a specified date. Registered staff #121, #111, #105 and #135 documented that resident #020 was eating poorly and becoming lethargic over an identified period of time. On an identified date, the notes revealed that nurse manager #123 assessed the resident to have a change in health condition and was sent to the hospital.

Review of resident #020's flow sheets and interview with PSW #144 resident #020 was experiencing a change in oral intake. This was reported to registered staff.

Interviews with registered staff #121, #105, and #135 and nurse managers #123 and #111 revealed they had been aware about resident #020 but no one had initiated a three day food and fluid record, nor had they assessed his/her health status. Interview with the RD revealed he/she did not assess resident #020's status because the referral he/she received on a specified date, only addressed one of the resident's issues and he/she could not recall even seeing the resident.

Interviews with registered staff #121, #105, and #135 and nurse manager #123 revealed that they do not believe the home has sufficient protocols in place to deal with this issue and they rely on their clinical background and skills. According to these staff members, they recently have the ability to refer to a nurse practitioner to assess and possibly initiate treatment. Interview with the DOC revealed there is no policy or procedure regarding this. Interview with the RD revealed he/she has not been approached by the home to develop any policies. Interview with the DOC confirmed the home's nutrition and hydration policy was incomplete and needed to be revised.

2. Record review and interview with family member #201 revealed that resident #043's health condition had been deteriorating since the resident had a fall on a specified date, and the resident had a history of an identified health condition.

Review of resident #043's progress notes revealed that on a specified date, a nurse practitioner recommended treatment for three days for an identified health condition.

Registered staff later documented that the resident was consistently eating poorly over a specified time period.

Interviews on a specified date with registered staff #121, nurse manager #123 and DOC confirmed that resident #043's health condition had changed in the specified period. According to registered staff #121, a three day food record had not been initiated because nursing staff did not receive the sheets from the dietary department and nursing had not referred the resident to the dietitian since a specified date. On an identified date, after the inspector inquired about the possibility of changed health condition due to poor intake and no relevant specific intake documentation, nurse manager #123 initiated a fluid intake and output sheet and notified a nurse practitioner. Interview with the DOC had already confirmed that the home needs to improve their identified program to give staff clear direction on how to identify those at risk and implement interventions to mitigate and manage the risks.[s. 68. (2) (a)]

3. The licensee has failed to ensure that heights are measured annually.

Record review revealed that heights are recorded annually on each resident's weight record and the inspector noted that the heights never deviate from their admission height. Interview with registered staff #104 revealed that heights are not measured annually. Interview with the DOC confirmed that the home does not measure residents' height annually. [s. 68. (2) (e) (ii)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Section 19. (1) of the LTCHA, 2007, was issued as a written notification and voluntary plan of correction as part of the Resident Quality Inspection (RQI) #2014_321501_0016 report dated November 26, 2014.

Due to the actual risk to residents as well as the above mentioned history of non-compliance, the following is being issued as an order:

The licensee has failed to ensure that residents are protected from abuse by anyone in the home.

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

Review of a critical incident report revealed a witnessed incident of staff to resident verbal abuse. On an identified date and time, the resident was entering the dining room and saw PSW staff #127 and commented that he/she had been waiting for the PSW for a long time. The resident demanded care services from the PSW. The PSW became angry and argued with the resident to the point of yelling at the resident in front of the other residents and staff. Another PSW intervened and removed the identified PSW from the dining room.

The incident was reported to the executive director (ED) who initiated an investigation. Meetings were called for the staff present at the dining room to meet with the ED and gave their account of the incident verbally. Following the investigation it was deemed that PSW staff #127 had been verbally abusive to the resident and his/her employment was terminated. The DOC submitted a critical incident report on specified date and time to the Ministry of Health & Long Term Care (MOHLTC).

The inspector conducted interviews with RPN staff #121, #137, and PSW staff #130 who had witnessed the abuse incident. The PSW staff #127 was witnessed to have a heated verbal exchange with the resident and was using profanities. The PSW staff #127 was escorted out of the dining room by PSW staff #146. While on his/her way out, the PSW staff #127 was observed to be still looking back at the resident in an angry manner. Interview with RPN staff #137 revealed he/she had previously witnessed PSW #127 speaking to the same resident in an abusive tone using profanities. RPN staff #137 stated that he/she did not report this abuse to anyone and was unable to provide a

specific date.

Interview with the DOC and ED confirmed the incident of staff to resident verbal abuse did occur to resident #044 on the above mentioned date and time.[s. 19. (1)]

2. Review of a critical incident report submitted by the home on a specified date and time revealed a suspected incident of staff to resident verbal abuse towards resident #045. The report revealed the resident was dependent on staff's assistance for activities of daily living. On a specified date and time, the resident was in his/her room and rang the call bell to be assisted. PSW staff #128 entered the room and said to the resident in a loud voice, "why are you calling me? I have things to do". The conversation was overheard by MOHLTC inspector #501. PSW staff #128 was interviewed by inspector #501 at the time and the PSW indicated that he/she has a hearing problem and that was the reason for speaking loudly to the resident. When asked why he/she was speaking to the resident in a scolding tone, the PSW expressed remorse, apologized and told the inspector that she/he would not do that again.

The inspector brought the incident to the attention of nurse manager #123. An investigation was initiated and PSW staff #128 was suspended for the day. Upon return to work, the PSW was re-educated on Residents' Bill of Rights and the home's abuse policy. The PSW continued to provide care to the residents on the same unit.

Interview with the resident revealed the resident could recall the incident, however did not know the name of the staff who talked loudly. The resident stated that he/she did not report the incident to anyone at the home but now knows he/she could talk to the nurses.

Interview with the DOC confirmed that the staff to resident verbal abuse did occur to the resident on the above mentioned date and time. [s. 19. (1)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs is fully respected and promoted.

On June 3, 2015, observations revealed resident #111 was left on a toilet with a partially closed door in a common bathroom. The bathroom was accessible to all residents.

Record review revealed resident #111 needed extensive assistance for toileting and was identified as having moderate cognitive condition.

Interview with staff members #107 and #110 revealed that they assisted resident #111 but did not close the door, nor did they pull the curtain around. They confirmed that resident #111 was not afforded privacy while staff were providing care.

Interview with nurse manager #123 confirmed that it is expected staff to provide privacy for residents by closing doors or pulling curtains when providing care. [s. 3. (1) 8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs is fully respected and promoted, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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 plan of care set out clear directions to staff

and others who provide direct care to the resident.

Review of resident #006's most recent written plan of care for toileting revealed the resident needs one person constant supervision and physical assistance for toileting and in the same section indicates the resident needs two person total assistance. The written plan of care revealed resident #006 wears incontinent products but does not specify the size.

Interview with PSW #116 indicated the written plan of care does not provide clear direction for care for resident #006. Interview with PSW #113 indicated the plan of care did not provide clear direction of when and how to care for the resident, nor the size of product to use. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences.

Interview with family member #200 revealed that resident #043 had been upset in the past because staff had not assisted the resident with his/her personal aid. An observation on June 22, 2015, revealed the resident had the personal aid. Interview with PSW #142 revealed resident #043 requires the use of a personal aid.

Record review of the RAI MDS assessment for a specific date revealed resident #043 has a specific health condition requiring a personal aid and the aid is not used regularly. Review of the most recent written plan of care revealed there is no indication resident #043 required a personal aid. Review of the kardex revealed that resident #043 has a specific health condition and does not use a personal aid.

Interview with RAI MDS Coordinator #114 and DOC confirmed that resident #043's plan of care does not include the resident's need for assistance with his/her personal aid and the expectation is that this should be included. [s. 6. (2)]

3. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Review of the admission progress notes of resident #043 revealed the resident was usually continent of bladder. Review of the minimum data set (MDS) assessment for the resident described the resident as totally incontinent of bladder.

Interview with RPN #121 confirmed that there was no indication of collaboration among registered nursing staff in the assessment of the resident's status. [s. 6. (4) (a)]

4. Review of a critical incident report revealed resident #041 had an accident on an identified date and time in his/her washroom. The resident required one staff to assist with activities of daily living, and was able able to use the toilet independently with an assistive device. At the time of the incident, the resident had been sitting on the assistive device in the washroom. Shortly after, staff discovered the resident was lying on his/her back on the floor with the assistive device beside him/her. Upon assessment, the resident complained of pain and was transferred to the hospital for further assessment. The resident was diagnosed with an injury.

Interview with resident #041 revealed he/she slipped from the assisstive device because it had broken off from the toilet.

Review of the plan of care revealed the resident had not been assessed for use of the assisstive device since admission. The assistive device was not addressed in the written plan of care.

Interview with PSW #122 and registered staff #121 confirmed the resident had been using the assistive device. Interviews with the PT indicated that he/she was not aware the resident was using the assistive device until after the incident. The PT indicated that he/she did not assess the resident for the use because he/she had not received a referral from nursing.

Interview with the EM indicated that the EM was not aware that the resident was using the assistive device. The EM stated that maintenance staff are always involved in making sure the assistive device is properly set and in working condition, but not the one that resident #041 was using prior to the incident.

Interview with the ED and DOC confirmed that the staff and others involved in the different aspects of care did not collaborate with each other in the assessment of resident #041 so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

5. The licensee has failed to ensure that staff and others involved in different aspects of care collaborate with each other in the development and implementation of the plan of

care so that the different aspects of care are integrated, consistent with and complement each other.

Review of the physician's orders for resident #005 revealed that an assessment was originally ordered on an identified date and there was no evidence that this occurred. Review of the physician's progress notes from a specified date, revealed resident #005's diet should be changed to an identified diet until the assessment was completed but this was not written as an order. Review of the physician's orders revealed the assessment was ordered a second time on a specified date. Review of the most recent plan of care and the dietary plan on an identified date, revealed resident #005 was on a specific diet due to some difficulties but had not been changed to the identified diet as previously recommended by the physician.

Interview with registered staff #137 revealed that he/she was unaware of the physician's recommendations because the change was not written and this registered staff member was not with the physician when an identified diet was recommended. This registered staff member stated that the physician usually would write an order to change a diet. Interview with the DOC and RD confirmed that the physician had not collaborated with nursing or dietary in the development and implementation to change resident #005's diet as there was no written order. [s. 6. (4) (b)]

6. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

On identified date, during the lunch meal, resident #005 was observed eating a sandwich on an identified type of bread. Record review of resident #005's meal plan indicated the resident is to be served sandwiches on a specified type of bread, different from the one identified during the observation. Interview with the dietary supervisor (DS) confirmed the resident should have been served sandwiches on the specified type of bread according to the resident's plan of care. [s. 6. (7)]

7. The licensee had failed to ensure that staff and others who provide direct care to a resident is kept aware of the contents of the plan of care and given convenient and immediate access to it.

Review of the most recent plan of care revealed that resident #009 is on a specified diet and intervention. Observation on an identified date revealed the resident had difficulty eating at dinner. The resident did not receive the intervention as specified. Interview with

PSW #143 who was serving this table revealed he/she was unaware that resident #009 required the intervention but thought this information was important in order to reduce risk to the resident. Review of the diet list and seating plan did not specify the intervention.

Interview with the DS indicated that PSWs do not necessarily serve residents in the dining room that are on their assignment and would not normally check the plans of care or kardexes for those they are serving in the dining room. The DS confirmed that staff serving in the dining room may not be aware of the plans of care for residents who need assistance as there is no convenient access to this information in the dining room. [s. 6. (8)]

8. The licensee has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary.

Record review revealed resident #006 was assessed for continence care on admission and was identified as continent of bowels and frequently incontinent of urine. The plan of care from an identified date indicated resident #006 was to be toileted by one person with constant supervision and physical assist for safety, to have clothing adjusted and hands washed and to have care performed.

Further record review of the progress notes revealed resident #006 experienced a fall on a specified date and experienced a change in the health status. After hospitalization the resident was recommended for bed rest and was no longer toileted. The RAI MDS record from a specified date indicated resident #006’s continence level had changed. Record review revealed resident #006 was not reassessed for the changes in his/her condition.

The home's policy titled Continence Care and Bowel Management stated that residents shall be reassessed quarterly by registered staff and/or when there is any change in the resident’s health status that affects continence.

Interview with PSW #113 and registered staff #114 confirmed that the resident was not reassessed for continence care after resident #006’s care needs changed.

9. Review of resident #009's health record revealed there was an Initial Activation Assessment in 2013 and monthly recreation participation records for 16 months thereafter. Further record review revealed resident #009's health condition had

deteriorated during an identified time period in 2015. Record review revealed there was no plan of care for activation and the resident had not been reassessed after a change in condition.

Interview with activation staff #125 and #126 confirmed that resident #009 was not assessed and the plan of care was not reviewed and revised after the resident's health condition declined. [s. 6. (10) (b)]

10. Review of resident #011's most recent RAI MDS Assessment revealed a decrease in participation in activity programs and there was no indication that the resident's activity preferences or pursuits were reassessed.

Interview with activation staff #125 and #126 confirmed that resident's participation in planned activities declined and he/she currently pursues other activities. Furthermore, the activation staff confirmed that resident #011 was not reassessed and the plan of care was not reviewed and revised to reflect those changes. [s. 6. (10) (b)]

11. Record review of resident #015's health record revealed an Initial Activation Assessment in 2013 and monthly recreation participation records for one months thereafter. Participation records for an identified period of time, indicated no attendance at any of the activities. RAI MDS assessment from a specific date indicated resident #015's activity participation had decreased due to a medical condition. Record review revealed there was no reassessment for the resident's activity preferences and pursuits.

Interview with activation staff #125 and #126 confirmed resident #015 had not been reassessed and the plan of care reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

12. Review of the physician’s orders for resident #043 revealed that the RD recommended a nutritional intervention on a specific date. On a different date the RD recommended to discontinue this intervention due to the resident's preference. One month later, the RD recommended a change in resident's diet order.

Review of the resident’s most recent written plan of care and kardex revealed the resident was not on the recommended diet and was receiving the nutritional intervention.

Interview with PSW #142 indicated he/she was unaware of the resident’s current diet and

whether he/she received the nutritional intervention. Interview with the RAI MDS Coordinator #114 and DOC confirmed that the plan of care for resident #043 had not been revised after the plan was no longer necessary and the care needs changed. [s. 6. (10) (b)]

13. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at any time when the care set out in the plan has not been effective.

Record review revealed that on an identified date the RD recommended a change in diet for one week and then reassess resident #043's acceptance/tolerance of the diet. Progress notes from an identified period of time revealed the resident was eating poorly.

Interviews on a specified date with registered staff #121, nurse manager #123 and DOC confirmed that resident #043's eating had changed for the last three weeks and his/her diet had not been reassessed. According to registered staff #121, a three day food and fluid intake had not been initiated because nursing had not received the sheets from the dietary department and nursing had not referred the resident to the RD since resident's eating changed.

Interview with the DOC confirmed that resident #043’s acceptance and tolerance of the diet was not reassessed. [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
-the plan of care sets out clear directions to staff and others who provide direct care to the resident,
-the plan of care is based on an assessment of the resident and the resident's needs and preferences,
-staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other,
-staff and others involved in different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated, consistent with and complement each other,
-the care set out in the plan of care is provided to the resident as specified in the plan,
-staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and given convenient and immediate access to it,
-the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, and,
-the resident is reassessed and the plan of care reviewed and revised at any time when the care set out in the plan has not been effective, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, procedure, strategy or system instituted or otherwise put in place is complied with.

Review of the home's policy titled Self-medication, document No. 14, from a specified date, states a resident may self-medicate only when ordered by the physician. The registered staff shall monitor the resident who is self-medicating weekly for one month and then monthly on or about the first of each month. The home's policy included a self-medication assessment record for monthly assessments to be completed on.

Record review of physician's orders for resident #008 revealed an order was written on a specified date that resident #008 may self-medicate using an identified medication.

Record review of the progress notes from a specified period of time revealed that weekly assessments were not completed by the registered staff.

Observation of the medication administration record (MAR) binder revealed that on the identified date the self-medication assessment record form for resident #008 was not present.

The next day an observation of the MAR binder revealed a self-medication assessment record was present and the assessment had been completed for the current month.

Interview with registered staff #105 revealed that resident #008 does self-medicate the identified medication and that neither the initial weekly assessments for one month nor the monthly assessments had been completed since the physician's order to self medicate.

Interview with the DOC revealed that the home had completed a self-medication assessment record for the current month after this was brought to their attention by the inspector and that previous monthly assessments had not been completed as per the home's policy.

Interview with the DOC confirmed that the registered staff had not complied with the home's policy on self-medication related to weekly assessments for a month after the initial physician order and monthly assessments thereafter. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 25. Initial plan of care

Specifically failed to comply with the following:

s. 25. (1) Every licensee of a long-term care home shall ensure that,
(a) the assessments necessary to develop an initial plan of care under subsection 6 (6) of the Act are completed within 14 days of the resident's admission; and O. Reg. 79/10, s. 25 (1).
(b) the initial plan of care is developed within 21 days of the admission. O. Reg. 79/10, s. 25 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the initial plan of care is developed with 21 days of admission.

Record review and interview with family member #200 revealed resident #020 was sent to the hospital on a specified date, due to a decline in health condition and passed away 29 days later.

Record review revealed that resident #020 was admitted to the home on specified date and was sent to the hospital two months later. Review of resident #020's plan of care in the home's electronic documenting system revealed that there were focuses, goals and interventions that were created three months after admission. Interview with RAI MDS Coordinators #114 and #118 revealed that this was due to an error and this plan of care was never in effect. They confirmed that at the time resident #020 went to the hospital, the home was still using an admission plan of care because an initial full plan of care had not been developed within 21 days of admission. [s. 25. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the initial plan of care is developed with 21 days of admission, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

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

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).

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

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

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment with respect to the resident's disease diagnosis.

Family interview and record review revealed resident #009 had a history of change in

medical condition and had been recently hospitalized for these conditions on identified dates. Interview with family member #203 revealed that the resident can become seriously ill if a change in the medical condition is not detected early.

Review of the resident's most recent written plan of care revealed that there is no indication that resident #009 had these medical conditions and there was no goals or interventions to monitor and assess the resident for these conditions.

Interview with the RAI MDS Coordinator #118 confirmed that this should be part of resident plan of care and he/she believed it got missed because it was not included in the list of medical diagnoses in the electronic documentation program to trigger the written plan of care. [s. 26. (3) 9.]

2. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment that includes the resident's health conditions including allergies.

Review of resident #009's health record revealed there were two copies of a handwritten list of medications that the resident was sensitive and allergic to. There was no other indication that resident #009 was allergic to any medication in the paper or electronic version of the health record.

Interview with RAI MDS Coordinator #118 revealed he/she did not know why the medication list was in the health record and would look into it. A follow-up interview with RAI MDS Coordinator #118 revealed that the family had obtained this list from the hospital in which the resident had been admitted to in the past and the family member had given it to someone at the home. The RAI MDS Coordinator was in the process of validating this information with the hospital and confirmed that this information needed to be part of resident #008's plan of care. [s. 26. (3) 10.]

3. The licensee has failed to ensure that a resident's plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including risk of falls.

Review of the admission fall risk assessment on a specified date for resident #043 revealed the resident was assessed to be at moderate risk of falls. The resident ambulated with assistance and had sensory problems. Review of the current written plan of care revealed no indication of any interventions established to address the resident's risk for falls.

Interview with RPN #121 and the DOC confirmed that there were no indications of any interventions established in the resident's plan of care to address the risks for falls. [s. 26. (3) 10.]

4. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's nutritional status including any risks related to nutrition care.

Review of resident #006's assessment by the RD on a specified date indicated that the resident was at high nutritional risk. He/she was ordered a nutritional supplement the month prior due to poor appetite. Review of the resident's weight history revealed that there had been significant weight loss since the last RD assessment. Review of the physician's orders revealed resident #006's diet was changed during the same time period the nutritional supplement was ordered and there was no assessment or reason given for this change in the progress notes.

Interview with the DOC revealed that nursing had communicated to the physician that resident #006 was having difficulty eating and had documented this in the 24-hour report which nursing use to communicate with each other on a daily basis. Interview with the RD revealed he/she did not receive a referral to assess resident #006's eating abilities.

Interview with registered staff #137, the RD and the DOC confirmed that resident #006's diet texture was changed without an interdisciplinary assessment. [s. 26. (3) 13.]

5. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's activity patterns and pursuits.

Record review revealed there was no plan of care for resident #015's activity patterns and pursuits.
Interview with resident #015 and staff member #115 indicated the resident attends only few activities but most of the time he/she has established his/her own activities of interest.

Interview with activation staff #125 and #126 confirmed they have not entered any plan of care for resident #015 regarding his/her activity preferences as they have not assessed the resident.

Interview with RAI MDS Coordinator #118 confirmed there is no plan of care for resident #015 to address his/her activity patterns and pursuits. [s. 26. (3) 16.]

6. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

Observations on four specified dates and times revealed resident #015 was in bed sleeping. On an identified date and time the resident had left the room and staff confirmed that he/she went out.

Resident #015's RAI MDS assessment record from an identified date revealed resident #015 is awake most of the time in the morning, afternoon and evening and there was no indication for sleeping patterns in resident #015's most recent plan of care.

Interview with resident #015 and PSW #115 indicated resident #015 prefers to stay in bed in the morning and have a snack in the room. Interview with RAI MDS Coordinator #118 confirmed resident #015 was not assessed and plan of care was not based on resident #015's sleep patterns and preferences. [s. 26. (3) 21.]

7. The licensee has failed to ensure that the RD who is a member of the staff of the home complete a nutritional assessment for the resident whenever there is a significant change in the resident's health condition.

Record review and interview with family member #201 revealed that resident #043's health condition had been deteriorating since the resident had an incident on an identified date.

Review of resident #043's progress notes from identified periods of time revealed:
- a nurse practitioner recommended treatment
- the RD recommended a change in the resident's diet order
- the resident was to be monitored for one week for acceptance of the revised diet order.

On six identified dates the resident ate poorly. On an identified date resident #043 experienced a change in his/her health status and was seen by a physician who ordered treatment. However, the resident continued to eat poorly.

Interviews with registered staff #121, nurse manager #123 and DOC confirmed that resident #020's health condition had changed and no one had communicated this to the

RD. According to registered staff #121 a three day food and fluid intake had not been initiated because nursing had not received the sheets from the dietary department.

After discussion with nurse manager #123, a three day food and fluid intake was initiated and a nurse practitioner was notified. Interview with the DOC confirmed that a referral to the RD should have been made and cannot explain why it had not been. [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
- the plan of care is based on an interdisciplinary assessment with respect to the resident's disease diagnosis,
- the plan of care is based on an interdisciplinary assessment that includes the resident's health conditions including allergies,
- the plan of care is based on an interdisciplinary assessment of the resident's nutritional status including height, weight and any risks related to nutrition care,
- the plan of care is based on an interdisciplinary assessment of the resident's activity patterns and pursuits,
- the plan of care is based on an interdisciplinary assessment of the resident's sleep patterns and preferences,
- the RD who is a member of the staff of the home complete a nutritional assessment for the resident whenever there is a significant change in the resident's health condition,, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of critical incident (CI) report submitted by the home revealed resident #042 had a fall which occurred on an identified date and time. Staff was alerted by the resident's roommate and found the resident on the floor in his/her room beside the bed. The resident sustained an injury and complained of pain shortly after. The resident was transferred to bed and then transferred to hospital for further assessment. The resident was diagnosed and had treatment at the hospital.

Review of progress notes and assessments revealed that an assessment was not conducted for the resident after the above mentioned fall.

Interviews with registered staff #104 and the DOC confirmed that an assessment was not conducted for the resident after the fall incident on the above mentioned date. [s. 49. (2)]

2. Review of progress notes revealed resident #043 had a fall on an identified date and time, when an identified PSW walked the resident to the washroom with a walker. The PSW had been walking behind the resident to support him/her. According to the PSW, the resident's knees felt weak after taking one step and the PSW assisted the resident to slide on the floor onto his/her knees. The resident was later assisted back to bed with the help of another PSW. No injury was noted at the time. The resident's family was notified the same morning regarding the fall. Record review revealed no indication that any post-fall assessment had been conducted after the resident's fall on the identified date.

Interviews with registered staff #121 and the DOC confirmed that a post fall assessment using a clinically appropriate assessment instrument that is specifically designed for falls was not conducted for the resident after he/she had a fall. [s. 49. (2)]

Additional Required Actions:

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

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of PSW Documentation Record revealed that on a day shift on a specified date, PSW #124 and on evening shift on the next day, PSW #115 documented resident #012

exhibited altered skin integrity. Further record revealed there was no skin assessment conducted by the registered staff to follow up with the PSW's initial assessment. Also the record revealed there was no documentation in the progress notes if resident #012 had been assessed after he/she exhibited altered skin integrity.

Interview with PSW #127 indicated that residents are assessed for skin integrity by PSWs every second bath in a week and this is documented in the PSW Documentation Record and Head to Toe Assessment Tool The PSW verbally reported to registered staff about each finding.

Interview with the DOC confirmed resident #012 was not assessed as it is expected by registered staff when he/she was identified by PSWs to have altered skin integrity. [s. 50. (2) (b) (i)]

2. Review of progress notes on an identified date revealed that registered staff documented altered skin integrity on an identified area of the body for resident #30. Review of the record titled PSW Documentation Record and Head to Toe skin Assessment indicated no completion of the assessment tool to confirm that skin assessment was completed after the staff had identified the skin impairment.

Interview with nurse manager #123 confirmed registered staff must assess residents after PSWs identify altered skin integrity. The nurse manager also confirmed resident #030 had not been assessed by registered staff based on the documentation.

Interview with RAI MDS Coordinator #118 confirmed resident #030 did not receive a skin assessment by a member of the registered staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment [s. 50. (2) (b) (i)]

3. Review of resident #043's progress notes revealed that the resident developed altered skin integrity on identified dates. Interview with RPN #121 and PSW #142 revealed that the resident had ongoing skin issues and was continually receiving a medicated cream. Record review revealed no indication of any skin assessment having been conducted by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Interview with RPN #121 and the DOC confirmed that skin and wound assessments were not conducted for resident #043 when altered skin integrity was identified. [s. 50. (2) (b)

(i)]

4. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wound, is assessed by a registered dietitian who is a member of the staff of the home.

Review of resident #043's progress notes revealed the resident developed altered skin integrity on an identified area of the body on an identified date. Interview with RPN #121 and PSW #142 revealed the resident had ongoing altered skin integrity in a second identified area of the body and was continually receiving a medicated cream, twice daily. Record review revealed no indication of any referral made to the registered dietitian (RD) for the altered skin integrity on or after the identified date when the altered skin integrity was first identified.

Interview with RPN #121 and the DOC confirmed it is the practice of the home to make referral to the RD when altered skin integrity is of a specified stage and not all circumstances of altered skin integrity. [s. 50. (2) (b) (iii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
- the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
- the resident exhibiting altered skin integrity, including skin breakdown and rashes has been assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident requires.

Review of the MDS assessment from an identified date for resident #043 revealed the resident was continent of bladder and bowel. Review of the MDS assessment from the next MDS assessment revealed a change in continence level. Record review revealed no indication of any assessment having been conducted for the resident between the above mentioned periods when the resident's continence levels changed.

Interview with RPN #121 and the DOC confirmed that every resident on admission or when there is a change in continence level, is to be monitored by PSWs for three days. After three days, registered staff conduct an assessment to confirm the reason for the change in continence level using a appropriate clinical assessment tool from the electronic documentation.

The DOC confirmed that resident #043 was not assessed for his/her care needs between the identified dates when the resident's continence level changed. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident requires, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the actions taken to meet the needs of the resident with responsive behaviours include: assessment, reassessments, interventions, and documentation of the resident's responses to the intervention.

Record review revealed that resident #003's responsive behaviours had worsened since his/her last assessment and was not reassessed when his/her care needs changed. Furthermore, the record revealed that resident #003 had experienced responsive behaviour that were not easily altered all the time.

Interview with the DOC confirmed that resident #003 had been identified with responsive behaviours and the home had notified the physician and the family. The physician had prescribed medication but the SDM refused the medications. Interview with nurse manager #123 revealed that resident #003 had experienced responsive behaviours and was referred to an outside specialist for further assessment and treatment. The day before the assessment, the clinic had canceled the appointment.

The DOC confirmed that after this the resident's condition continued to worsen and the home did not take any further or alternative action. [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the actions taken to meet the needs of the resident with responsive behaviours include: assessment, reassessments, interventions, and documentation of the resident's responses to the intervention, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure when there is no Family Council that semi-annual meetings are convened to advise residents' families and persons of importance to residents of their right to establish a Family Council.

Review of the June 2015, newsletter revealed the home is looking to start a Family Council. Interview with the ED and AED revealed the home does not convene semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council. [s. 59. (7) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure when there is no Family Council that semi-annual meetings are convened to advise residents' families and persons of importance to residents of their right to establish a Family Council, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance.

On a specified date, observations revealed resident #031 in bed coughing while eating breakfast. The head of the bed was elevated at 45 degrees and an over-bed table was positioned on the long side of the bed with a tray on it. Resident #031 was in an awkward position and was trying to cough out a particle of food. With approval of the resident, the inspector called for staff to assist.

Interview with registered staff #104 who assisted resident #031 into safe positioning, confirmed the resident had not been safely positioned for eating and the home's expectation is for the resident to be positioned at 90 degrees. [s. 73. (1) 10.]

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 proper techniques are used to assist residents with eating,including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

Interview with family member #203 revealed there are washrooms within the home with lingering offensive odours.

Observations revealed there was a strong odour of urine in some of the shared washrooms on the following dates:
• On June 12, 2015, at approximately 1:00 p.m.
• On June 15, 2015, at approximately 9:00 a.m.
• On June 15, 2015, at approximately 11:30 a.m.

Review of the home's policy titled Accommodation Services Housekeeping revealed that staff are provided with products to help to minimize odours and are to seek help from their manager if unsatisfied with results.

Interview with housekeeper #145 revealed the home uses a neutralizer spray for offensive odours and he/she will usually double mop.

Interview with the EM revealed that the home was aware of the lingering urine odour in identified rooms but was unaware of the odour in one specified room. It was revealed that housekeepers have not been reporting the issue of lingering odours and have not been able to deal with it. According to the EM, the odours have been found to be caused by various reasons and different procedures need to be identified and written in a policy and procedure in order to guide staff on best practices. [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed, no later than one business day after the occurrence of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Review of a critical incident report and progress notes for resident #040 revealed on an identified date and time, the resident was found on the floor beside his/her bed. The resident was assessed to be confused and stated that he/she wanted to go to the washroom. The resident was transferred by two staff using a mechanical lift. The resident was assessed post fall and there were no noted injuries. The resident was wheelchair bound and totally dependent with all activities of daily living. The physician was in the home that day, assessed the resident and ordered an x-ray. On the day following the fall, staff noted a change in the resident's physical appearance. The physician was notified and the resident was transferred to hospital. The resident was diagnosed with an injury. The incident occurred on a specified date and the critical incident (CI) report was submitted to the ministry of health and long term care (MOHLTC) on the identified date.

An amendment was requested by MOH on another identified dates. As of dates after that, no amendments were received from the home.

Interview with the DOC confirmed that the home did not submit the CI report of the resident's fall on the specified date with injury and the eventual transfer to hospital until 26 days after the occurrence of the incident. An amendment was sent to the MOH from the home after the inspector interviewed with the DOC. [s. 107. (3) 4.]

2. Review of critical incident report revealed that resident #041 required one staff assist for activities of daily living, and was able to use the toilet independently with an assistive device. On an identified date and time the resident used the washroom. Shortly after, staff discovered the resident on the floor in his/her bathroom, lying on his/her back with the assistive device beside him/her on the floor. The resident stated that he/she slipped from the toilet seat. Upon assessment, the resident complained of pain and was transferred to hospital for further assessment. The resident was diagnosed and received treatment. A critical incident report was submitted by the home to MOH on an identified date 27 days after the incident.

Interview with the DOC confirmed that the critical incident report on the above mentioned fall incident and the transfer to the hospital of the resident was not reported to the Director until 27 days after the occurrence of the incident. [s. 107. (3) 4.]

3. Review of a critical incident report submitted by the home revealed resident #042 had a fall on an identified date and time. Staff was alerted by the resident's roommate and found the resident on the floor in his/her room beside his/her bed. The resident sustained an injury and complained of pain shortly after. The resident was transferred to bed and then transferred to hospital for further assessment. The resident was diagnosed and had treatment at the hospital. An initial critical incident report was faxed to the MOH on identified date. A CI report was later submitted via the critical incident system (CIS) on another date.

Interview with the DOC confirmed that the CI report was submitted to the MOH 25 days after the occurence of the incident. [s. 107. (3) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is informed, no later than one business day after the occurrence of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs that are stored in an area or in a medication cart comply with manufacturer's instructions for the storage of the drugs.

Observations on June 9, 2015, revealed the following expired drugs:
-in the vaccine fridge, two boxes containing 10 pre-filled syringes each of Fluad, with an expiration date of March 2015
-in the government stock cupboard, 1 bottle of Potassium Chloride 20mEq/15 ml oral suspension, with an expiration of January 2015 and one opened bottle of Senekot tablets with an expiration date of May 2015.

Interview with the infection control lead revealed that he/she audits the vaccine fridge and government stock medications for expiry dates on a monthly basis and confirmed that these expired medications should have been removed. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs that are stored in an area or in a medication cart are comply with manufacturer's instructions for the storage of the drugs, specifically expiration dates, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that a monthly audit is undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies, and that immediate action is taken if any discrepancies are discovered.

Interview with the DOC revealed and confirmed that a monthly audit of the daily count sheets of controlled substances are not completed to determine if there are any discrepancies so that required immediate action is taken if any discrepancies are discovered.

At the time of the interview, the DOC revealed that a monthly audit of the daily count sheets of controlled substances will be implemented. [s. 130. 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 ensure that a monthly audit is undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies, and that immediate action is taken if any discrepancies are discovered, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug record is established, maintained and kept in the home for at least two years, in which the following information is recorded in respect of every drug that is ordered and received in the home.

On an identified date observations revealed some of the medications were entered into the drug record book as ordered on identified dates, but were not signed in when received:
-30 TAB Quetiapine 25 mg
-15 TAB Lorazepam 1 mg
-30 TAB Tylenol #3
-30 TAB Tylenol #3
-500 ML Lactulose 667mg/ml
-500 ML Soflax Syrup 4mg/ml
-15 TAB Tylenol #3
-30 TAB Mar-Tramadol/Acet 37.5/325 mg.
On identified date, observation of medication cart with registered staff #105 revealed that all of the above mentioned medications had been received by the home on the evening of the identified date, and had not been signed in.

Interview with the DOC revealed that medications are delivered in the evening from the home's pharmacy provider and the evening registered staff are required to sign the drug record when an ordered medication is received. The DOC confirmed that the home's registered staff had not signed the drug record book indicating that the above mentioned medications had been received by the home. [s. 133.]

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 drug record is established, maintained and kept in the home for at least two years, in which the following information is recorded in respect of every drug that is ordered and received in the home, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and O. Reg. 79/10, s. 136 (3).

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

s. 136. (5) The licensee shall ensure,
(a) that the drug destruction and disposal system is audited at least annually to verify that the licensee's procedures are being followed and are effective; O. Reg. 79/10, s. 136 (5).
(b) that any changes identified in the audit are implemented; and O. Reg. 79/10, s. 136 (5).
(c) that a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 136 (5).

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a drug that is to be destroyed is a controlled substance, it will be done by a team acting together and composed of:
i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and

ii. a physician or a pharmacist.

Review of the home's policy titled Drug Destruction, dated May 13, 2015, states that the nursing staff shall keep an accurate record of the date surplus or discontinued medication are removed for destruction on the appropriate Ministry form, the pharmacist and the DOC will audit the form and that narcotic medication will be double locked in a separate container until picked up by the pharmacist.

Interview with the DOC revealed that all discontinued or surplus narcotic medications are removed from home by the pharmacist who then takes them back to the pharmacy where drug destruction occurs.

Interview with the consulting pharmacist for the home confirmed that narcotic medication destruction occurs in the pharmacy. [s. 136. (3) (a)]

2. The licensee has failed to ensure that where a drug that is to be destroyed is not a controlled substance, it will be done by a team acting together and compromised of:
i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
ii. one other staff member appointed by the Director of Nursing.

Review of the home`s policy titled "Drug Destruction" dated May 13, 2015, states that the nursing staff shall keep an accurate record of the date surplus and discontinued medications are removed for destruction on the appropriate Ministry form, the pharmacist and the DOC will audit the form and the pharmacist will be contacted and arrange the pick up of all surplus medications.

Interview with the DOC and consulting pharmacist confirmed that surplus and discontinued medications are removed from the home by the pharmacist and taken to the pharmacy for drug destruction. [s. 136. (3) (b)]

3. The licensee has failed to ensure that the drug destruction and disposal system is audited at least annually to verify that the licensee's procedures are being followed and are effective.

Interview with the DOC and the ED confirmed that the home's drug destruction and disposal system is not audited at least annually to verify that the practices in place are being followed and are effective.

The ED revealed that at the home's next pharmacy and therapeutics meeting scheduled for August 17, 2015, the home will initiate the annual audit of the drug destruction and disposal system. [s. 136. (5)]

4. The licensee has failed to ensure that when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

Review of the home`s policy titled Drug Destruction, dated May 13, 2015, does not reflect the altering or denaturing of a drug to such an extent that its consumption is rendered impossible or improbable when being destroyed.

Interview with the home`s consulting pharmacist revealed that the the pharmacy has a drug disposal service that picks up any drugs that are being destroyed.

Interviews with the DOC and the consulting pharmacist for the home confirmed that when a drug is being destroyed it is not altered or denatured to such an extent that its consumption is rendered impossible or improbable. [s. 136. (6)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
- when a drug that is to be destroyed is a controlled substance, it will be done by a team acting together and composed of:
i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
ii. a physician or a pharmacist
- to ensure that where a drug that is to be destroyed is not a controlled substance, it will be done by a team acting together and compromised of:
i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
ii. one other staff member appointed by the Director of Nursing,
- the drug destruction and disposal system is audited at least annually to verify that the licensee's procedures are being followed and are effective,
- when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable, to be implemented voluntarily.

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 215. Criminal reference check

Specifically failed to comply with the following:

s. 215. (1) This section applies where a criminal reference check is required before a licensee hires a staff member or accepts a volunteer as set out in subsection 75 (2) of the Act. O. Reg. 79/10, s. 215 (1).

s. 215. (2) The criminal reference check must be,
(a) conducted by a police force; and O. Reg. 79/10, s. 215 (2).
(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee. O. Reg. 79/10, s. 215 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a criminal reference check is obtained before hiring a staff member.

Record review revealed that:
• Staff member #133 had a clear criminal reference check 10 days after he/she had started to work at the home.
• Staff member #134 had a clear criminal reference check five months after he/she had started to work at the home.

Interview with the ED confirmed that the above mentioned criminal reference checks were not obtained before the hiring of staff members #133 and #134. [s. 215. (1)]

2. The licensee has failed to ensure that a criminal reference check is conducted within six months before the staff member is hired.

Record review revealed that staff member #135 had a clear criminal reference check nine years before he/she started to work at the home. Interview with the ED confirmed that this criminal reference check was not conducted within six months before the staff member was hired. [s. 215. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
- a criminal reference check is obtained before hiring a staff member,
- a criminal reference check is conducted within six months before the staff member is hired, to be implemented voluntarily.

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff are provided annual training in falls prevention and management.

Review of the training record for direct care staff revealed that 34 per cent of staff had not received training in falls prevention and management in 2014.

Interview with the DOC confirmed that 84 per cent of direct care staff did not receive training in falls prevention and management in 2014. [s. 221. (1) 1.]

2. The licensee has failed to ensure that direct care staff are provided annual training in continence care and bowel management.

Record review revealed there was no annual training in continence care and bowel management for direct care staff.

Interview with staff members indicated they did not have a training regarding continence care and bowel management.

Interview with nurse manager #123 confirmed there was no annual training in continence care and bowel management. [s. 221. (1) 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 ensure that:
- direct care staff are provided annual training in falls prevention and management,
- direct care staff are provided annual training in continence care and bowel management, to be implemented voluntarily.

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Infection Prevention and Control program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Review of the Toronto Public Health (TPH) recommendations for Tuberculosis (TB) Screening in
Long Term Care (LTC) and Retirement Homes updated February 14, 2013, revealed that tuberculin Skin Tests (TST) are not recommended to be done upon admission for residents 65 years of age or older. A review of the Canadian TB Standards, 6th edition, advises that residents 65 years of age and older of LTC institutions undergo baseline posterior-anterior and lateral chest X-rays.

Record review of immunization records for the following three residents 65 years of age or older and admitted on specific dates, revealed TB screening was done using the TST:
- resident #031
- resident #006
- resident #032.

Interview with the DOC confirmed that the home's Infection Prevention and Control Program is not evaluated and updated in accordance with evidence-based or prevailing practices. [s. 229. (2) (d)]

2. The licensee has failed to ensure that there is a designated staff member to co-ordinate the
infection prevention and control program with education and experience in infection prevention and control practices including:
(a) infectious disease
(b) cleaning and disinfection
(c) data collection and trend analysis
(d) reporting protocols and
(e) outbreak management.

Interview with the DOC confirmed that staff member #102, who co-ordinates the infection prevention and control program, just started his/her role and has no education or experience in infection prevention and control practices including infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management. Record review revealed there was no specific training for this staff member.

Interview with the ED confirmed that registered staff #102 does not have any specific qualifications for infection prevention and control but will be attaining this training and education. [s. 229. (3)]

3. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

On identified date the inspector observed registered staff #112 administering medications in a hallway without performing hand hygiene before administering medication to four residents.

Interview with registered staff #112 confirmed that he/she did not clean his/her hands when administering medication as was expected by the home.

Interview with nurse manager #123 confirmed that it is expected that staff perform hand hygiene before administering medication to each resident. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
- the Infection Prevention and Control program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices,
- there is a designated staff member to co-ordinate the infection prevention and control program with education and experience in infection prevention and control practices including:
(a) infectious disease
(b) cleaning and disinfection
(c) data collection and trend analysis
(d) reporting protocols and
(e) outbreak management,
- staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #25: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed neglect of a resident by the licensee or staff that the licensee knows of, or that is reported is immediately investigated.

Interview with resident #011 revealed an incident when the resident pulled the call bell to request assistance to the washroom on an identified date and time when a designated PSW for the shift did not respond. According to the resident, he/she put him/herself on and off the toilet after a while. The resident could not remember how long he/she waited. The resident stated that after toileting self, the resident wheeled him/herself out to the hallway and noted some PSWs sitting in the lounge. The resident could not identify the PSWs' names. The resident felt neglected and reported the incident to nurse manager #123 at an identified time the same day. The nurse manager informed the resident that he/she will look into who was the PSW assigned to care for the resident and find out why the PSW did not answer the resident's call bell.

Interview with the nurse manager on identified date, revealed that the resident did report the incident to the nurse manager. There was no indication that an investigation was initiated by the nurse manager of the suspected neglect, and no report was made to the DOC nor the MOH. Interview with the DOC confirmed that the indent was not reported to him/her and as a result it was not reported to the Ministry of Health (MOH). The nurse manager submitted a written investigation note to the inspector. The PSW involved was identified to be PSW #124 who stated that he/she was taking another resident to a shower and therefore did not respond to the resident's call bell in a timely manner. A critical incident report was submitted via the Critical Incident System (CIS) on identified date and time by the DOC. [s. 23. (1) (a)]

WN #26: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraining of a resident by a physical device may be included in a resident's plan of care only if ordered or approved by a physician or registered nurse in the extended class.

Review of progress notes and restraint monitoring record for resident #042 revealed that two full length bed rails were applied to restrain the resident starting on an identified date, without a physician's order. A consent from the substitute decision-maker (SDM) was noted on the chart signed on an identified date.

Interviews with RPN #104 and the DOC confirmed that the full length bed rails were used to restrain the resident without an order from the physician. [s. 31. (2) 4.]

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 59. Therapy services
Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include,
(a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs; and
(b) occupational therapy and speech-language therapy. O. Reg. 79/10, s. 59.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident receives speech-language therapy services based on his or her assessed needs.

Review of the physician's orders for resident #005 revealed a swallowing assessment by a speech language pathologist was ordered on a specified date. The physician documented that the family had requested this assessment because the resident had difficulty swallowing.

Interview with registered staff #137 and record review revealed there was no indication that this assessment was ever performed. Interview with the DOC confirmed this assessment did not occur and the resident did not receive speech-language therapy services based on his/her assessed needs. [s. 59. (b)]

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with a change of five per cent of body weight, or more, over three months is assessed using an interdisciplinary approach.

Record review revealed that resident #006 experienced significant weight loss representing a change of six per cent of body weight over an identified one month period of time. Record review revealed that this weight loss had not been assessed.

Review of the home's policy titled Weight Changes, dated January 1, 2011, stated that a change of five per cent over a one month period is to be assessed by the dietitian and physician.

Interview with registered staff #137, the DOC and the RD confirmed that this weight change was not assessed. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

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

s. 116. (3) The annual evaluation of the medication management system must,
(a) include a review of the quarterly evaluations in the previous year as referred to in section 115; O. Reg. 79/10, s. 116 (3).
(b) be undertaken using an assessment instrument designed specifically for this purpose; and O. Reg. 79/10, s. 116 (3).
(c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 116 (3).

Findings/Faits saillants :

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

Interview with the DOC revealed that when the annual evaluation of the medication management system in the home is conducted, a registered dietitian (RD) is not a member of the interdisciplinary team.

Review of the home's pharmacy and therapeutics meeting minutes for November 17, 2014, revealed that a registered dietitian was not in attendance.

Interview with the ED confirmed that a RD had not been in attendance for any pharmacy and therapeutics meetings and that the RD will be asked to participate. [s. 116. (1)]

2. The licensee has failed to ensure that the annual evaluation of the medication management system includes a review of the quarterly evaluations in the previous year and is completed on an assessment instrument designed specifically for this purpose.

Interview with the DOC revealed that the annual evaluation of the medication management system is completed during the last professional advisory committee (PAC) meeting of the year. PAC meetings are held quarterly, the third Monday, every February, May, August and November yearly. The DOC also revealed that the home refers to their PAC meetings as the pharmacy and therapeutics committee (PTC).

Review of the home`s PAC meeting minutes for November 17, 2014, reveal the following medication issues:
-proper procedures for the nurses to follow from the time a blister pack is received to the time it goes into the drug destruction bins
-what to do with inhalers/liquids/eye drops, once a bottle/device is received
-faxing of the emergency drug box log sheet when a medications is used from the emergency drug box
-new orders or medication changes are not being received by the pharmacy in a timely manner.
The above mentioned medication issues were only documented in the PAC meeting

minutes and not on an assessment instrument specifically designed for the purpose of an annual evaluation of the medication management system.

Interviews with the DOC and executive director (ED) revealed and confirmed that the annual evaluation of the medication management system is not documented on an assessment instrument specifically designed for this purpose. [s. 116. (3)]

WN #30: 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. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that any resident who is permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room.

On a specified date, the inspector observed a medication found on the top of resident #008's bedside table. Interview with registered staff #105 revealed that resident #008 self-administers the medication as needed.

Record review of the home's policy titled Self-medication, document #14, revealed that a resident may self-medicate when ordered by the physician. The pharmacy service provider is notified via electronic order or verbally by a member of the registered staff. As part of the home's monitoring, the registered staff are to ensure the medication is safely stored.

Interview with the DOC revealed that she/he was not aware that resident #008 was self-administering the medication and confirmed that the medication was not being stored safely. [s. 131. (7)]

WN #31: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

Record review of the home's pharmacy and therapeutics committee meeting minutes for specified dates, do not reflect a review of medication incidents or adverse drug reactions.

Interviews with the DOC and pharmacy consultant #117 confirmed that any medication incidents or adverse drug reactions are investigated only at the time of occurrence and not reviewed at the quarterly pharmacy and therapeutics committee meetings. [s. 135. (3)]

WN #32: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record is created and maintained for each resident of the home.

Record review revealed that the following residents' records did not have their names or dates the records were created.

1) Resident #011 - fall risk assessment, pain and smoke assessment
2) Resident #041 - fall risk assessment
3) Resident #042 - fall risk assessment

Interview with RPN #121 and the DOC confirmed that the residents' names and the effective dates the records were created or were expected to be written on the records. [s. 231. (a)]

Issued on this 20th day of January, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GORDANA KRSTEVSKA (600), JOANNE ZAHUR (589), SUSAN SEMEREDY (501), TILDA HUI (512)
Inspection No. / No de l'inspection :	2015_302600_0012
Log No. / Registre no:	T-1755-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 23, 2015
Licensee / Titulaire de permis :	ROYAL CANADIAN LEGION DISTRICT 'D' CARE CENTRES 59 Lawson Rd, TORONTO, ON, M1C-2J1
LTC Home / Foyer de SLD :	TONY STACEY CENTRE FOR VETERANS' CARE 59 Lawson Road, TORONTO, ON, M1C-2J1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CATHERINE HILGE

To ROYAL CANADIAN LEGION DISTRICT 'D' CARE CENTRES, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_321501_0016, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA s.76(4) to ensure that all staff receive retraining annually related to the Residents' Bill of Rights, zero tolerance of abuse and neglect, mandatory reporting under section 24 and whistle blowing protection.

The plan must include:
- Who will be responsible for the retraining;
- When each retraining will be completed;
- When the home anticipates all staff to be retrained.

The plan is to be emailed to Susan.Semeredy@ontario.ca on or before December 15, 2015.

Grounds / Motifs :

1. This section of the LTCHA, 2007, s.76 (4) was issued as order #003 as part of the Resident Quality Inspection (RQI) #2014_321501_0016 report dated November 26, 2014.

Due to the risk to residents, the scope of the non-compliance as well as the above mentioned previous order, the following has been reissued:

The licensee has failed to ensure that all staff receive retraining annually related to the Residents' Bill of Rights; zero tolerance of abuse and neglect; mandatory reporting under section 24 and the whistle-blowing protections afforded by section 26.

Review of staff training records for 2014/2015 indicated 69 per cent of staff did not receive retraining related to the zero tolerance of abuse and neglect. There was no evidence that any staff received retraining related to the Residents' Bill of Rights, mandatory reporting under section 24 and the whistle-blowing protections afforded by section 26.

Interview with staff # 129 and ED confirmed staff were not provided with retraining for the above mentioned areas and the numbers presented in the training record were correct. (600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2014_321501_0016, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

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

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O.Reg. 79/10 s.30(1) to ensure that the following is complied with in respect to each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of O.Reg.79/10.

1. The licensee shall ensure that there is a written description for all programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of O.Reg.79/10. Specifically but not limited to:
• Dietary services and hydration,
• Recreation and social activities,
• Accommodation services, housekeeping; and,
• Skin and wound.
The written description must include its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources.

2. The licensee shall ensure that all programs under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of O.Reg.79/10, are evaluated and updated at least annually in accordance with evidenced-based practices and, if there are none, in accordance with prevailing practices. The licensee shall keep a written record relating to each evaluation that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.
The plan is to be emailed to Susan.Semeredy@ontario.ca on or before December 15, 2015.

Grounds / Motifs :

1. This section of the O.Reg. 79/10, s.30(1) was issued as order #001 as part of the Resident Quality Inspection (RQI) #2014_321501_0016 report dated November 26, 2014.

Due to the risk to residents, the overarching scope of the noncompliance as well as the above mentioned previous order, the following is being reissued:

The licensee has failed to ensure that the following is complied with in respect of

each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation.

There must be a written description of the program that includes its goals and objective and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Interview with the ED, AED and DOC revealed that none of the programs that were identified in the order from last year's RQI had not been updated to include:
• Goals and objectives,
• Relevant policies, procedures and protocols,
• Methods to reduce risk and monitor outcome, including protocols for the referral of residents to specialized resources.
The managers stated that even though they have created a policy, form and schedule to evaluate programs annually, no evaluations have yet to be completed and the programs have not been updated.

Programs identified during this inspection as not meeting this requirement include:

HYDRATION
The legislation, LTCA 2007, c.8, s.11 (1)(a) requires that there is an organized program of hydration for the home to meet the hydration needs of residents.

Inspector #501 asked the DOC for the home's policy regarding hydration in relation to an intake being completed during the Resident Quality Inspection (RQI) and received two different policies. Review of these policies revealed the following:
1. Maintaining Proper Hydration dated May 1, 2015:
• This policy has an opening section that refers to a resident's food intake but does not include fluid intake.
• The opening sentence also refers to a three day food intake monitoring record to be implemented for the dietitian to review for residents with significant change. There is no description of what significant change is.
• The policy and procedure goes on to describe dietary's role in assessing a resident's nutritional status and there is no indication what nursing's role is or

how the interdisciplinary team works together.
• The procedure states that measures shall be taken to identify and address those at high nutritional risk or at risk of dehydration but does not describe the measures that are to be taken.
• The policy then describes risks related to nutrition and or hydration but does not include methods to reduce these risks or monitor outcomes and when to refer to resources such as the dietitian.
• The rest of the policy includes mealtime assistance addressing positioning, staffing levels and assisting residents.
• The policy then ends with a statement that the program of nutritional care shall be evaluated annually for effectiveness.

2. Hydration Management (hypodermoclysis) dated January 12, 2013:
• There is no mention of hypodermoclysis in this policy even though the title indicates this is included.
• There is a list of classic signs and symptoms as an initial assessment for dehydration but does not include any strategies or interventions to address dehydration should that be diagnosed.
• The policy states to monitor resident's hydration status based on dehydration risk assessment checklist but there is no checklist included.
• There is no mention of referring to specialized resources.

Interview with the ED, AED and DOC confirmed that this hydration program does not meet the requirements as listed in the Regulation.

RECREATION AND SOCIAL ACTIVITIES
The legislation, LTCHA 2007, c.8, s. 10(1), requires that there is an organized program of recreational and social activities for the home to meet the interests of the residents.

Inspector #600 found that resident #009, #011 and #015's activity patterns and pursuits were not being reassessed and their plans of care reviewed at times when their care needs changed. Interviews with activation staff #125 and #126 revealed that the department did not have a lead for several months. Interview with the ED confirmed that there was no lead for this department from February of this year to June 22, 2015, and could not provide any relevant policies, procedures or protocols to guide staff in the interim.

DIETARY SERVICES

The legislation, LTCA 2007, c.8, s.11 (1), requires that there is an organized program of nutrition care and dietary services for the home to meet the daily needs of residents.

Inspector #501 found that significant weight change for resident #006 was not assessed by an interdisciplinary team. Review of the home's policy titled Weight Changes dated January 1, 2011, states that if a resident has significant weight change, the charge nurse is to refer the resident to the dietitian for further assessment. Interview with the RD revealed that she does not always get referrals for weight change, often checks the weight books for changes and there are times when changes get missed. Interview with the DOC revealed that once weight change is identified, the registered staff start monitoring the resident's intake more closely and refer to the RD. There is no indication in the policy that registered staff are to do anything but refer to the dietitian. In addition, the policy states that if the body weight value appears to be incorrect i.e. great variance from previous weights, then the charge nurse will have the resident reweighed. There is no indication what constitutes great variance for reweighs so that referrals to the RD may be made for those residents that were simply weighed incorrectly.

Interview with the DOC confirmed that the policy for weight change does not provide methods to reduce risk and monitor outcomes and the RD confirmed that protocols for the referral of weight changes are not consistent. The ED confirmed that the home does not have a nutrition care and dietary services program to meet the needs of residents.

ACCOMMODATION SERVICES
The legislation, LTCA 2007, c.8, s. 15(1), requires that there is an organized program of housekeeping for the home.

Review of the housekeeping policy revealed there is no description regarding specific procedures for the cleaning of resident bedrooms, common and staff areas. There is no procedure for cleaning and disinfecting resident care equipment, the safe removal of wet and dry garbage or procedures to address lingering offensive odours. The AED confirmed that this policy does not meet the requirement to reduce risk and monitor outcomes and indicates that the home lacks an organized program of housekeeping.

SKIN AND WOUND CARE PROGRAM

The legislation, O.Reg. 79/10, s.48(1)(2), requires that there is a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

Interview with managers confirmed that the skin and wound care program does not provide methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources, including the RD.

Review of the home's policy titled Skin and Wound Management and Prevention dated August 17, 2014, revealed that a skin assessment is done on all residents regularly on bath days. In another section of the policy it states that PSWs are to complete skin assessments with every other bath monthly and report altered skin integrity immediately to registered staff. Inspector #600 found that the recording of skin being intact or not by PSWs was dependent upon whether the flow sheet included an available space for this documentation.

Review of the home's policy revealed there is no definition for altered skin integrity and only addresses stages of pressure ulcers. As per the O.Reg 79/10, s.50(3) "altered skin integrity" means potential or actual disruption of epidermal or dermal tissue. In s.50(2)(b) altered skin integrity includes skin breakdown, pressure ulcers, skin tears or wounds. Inspector #512 found that there were no skin assessments for skin rashes and that residents were not always assessed by a registered dietitian. It was found that the practice of the home is to make a referral to the RD only with stage II or greater pressure ulcers. Review of the home's policy states that registered staff are to send a referral to the RD immediately when a resident exhibits altered skin integrity however since the policy does not define altered skin integrity this is open to interpretation. To further confuse staff, the policy includes a form to the dietitian that includes "decubitus ulcers" as an indicator to check for referral but nothing for "altered skin integrity".

Interview with managers confirmed that the skin and wound care program does not provide methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources, including the RD.

During the course of this inspection, inspector #501 had conversations with the ED regarding the lack of organized programs. The ED confirmed that this had to become a priority as there were many negative outcomes for residents as evidenced by the number of findings of noncompliance found during this

inspection. (501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,

(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;

(b) the identification of any risks related to nutrition care and dietary services and hydration;

(c) the implementation of interventions to mitigate and manage those risks;

(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

(e) a weight monitoring system to measure and record with respect to each resident,

(i) weight on admission and monthly thereafter, and

(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure:

1. A hydration program is developed and implemented, in consultation with a registered dietitian who is a member of the staff of the home. The program is to include but not limited to:
• monitoring and evaluating the hydration status of residents at risk for dehydration on a daily basis by registered staff;
• ensuring direct care staff including registered staff understand what constitutes poor fluid intake and over what time period;
• ensuring all direct care staff can identify residents at risk and act appropriately to ensure the risk of dehydration is addressed; and,
• implementing a documentation system to identify fluid intake on a daily basis for all at risk residents that easily identifies total daily fluid intake.

2. All direct care staff are educated on the home's hydration program related to identifying risks to residents' hydration and the implementation of interventions to mitigate and manage the risks.

The plan must be submitted by e-mail to Susan.Semeredy@ontario.ca on or before December 15, 2015.

Grounds / Motifs :

1. 1. Due to the serious risk for residents the following is being issued as an order:

The licensee has failed to ensure that the hydration program includes the development and implementation of policies and procedures relating to hydration in consultation with a dietitian who is a member of the staff.

Review of the home's policy titled Maintaining Proper Hydration dated May 1, 2015, indicated that a three day food intake monitoring record will be implemented for the dietitian to review for residents with significant change and a referral is to be sent for further assessment. There is no indication what constitutes significant change and when exactly referrals are to be sent. Another policy titled Hydration Management dated January 12, 2013, indicated that staff should observe and monitor for classic signs and symptoms of dehydration, assess these signs and symptoms, monitor hydration status, develop interventions to address hydration as needed, encourage resident and family participation and evaluate and document resident outcome and update

the care plan. There is no indication exactly what interventions staff are to take or specific protocols to follow.

Record review revealed that resident #020 was admitted to the home on a specified date and was sent to the hospital where he/she passed away. Record review and interview with family member #202 revealed the resident was sent to the hospital due to poor intake of food and fluids and was diagnosed with an identified health condition.

Review of resident #020's progress notes revealed that a family member was concerned that the resident had an identified health condition on a specified date. Registered staff #121, #111, #105 and #135 documented that resident #020 was eating poorly and becoming lethargic over an identified period of time. On an identified date, the notes revealed that nurse manager #123 assessed the resident to have a change in health condition and was sent to the hospital.

Review of resident #020's flow sheets and interview with PSW #144 resident #020 was experiencing a change in oral intake. This was reported to registered staff.

Interviews with registered staff #121, #105, and #135 and nurse managers #123 and #111 revealed they had been aware about resident #020 but no one had initiated a three day food and fluid record, nor had they assessed his/her health status. Interview with the RD revealed he/she did not assess resident #020's status because the referral he/she received on a specified date, only addressed one of the resident's issues and he/she could not recall even seeing the resident.

Interviews with registered staff #121, #105, and #135 and nurse manager #123 revealed that they do not believe the home has sufficient protocols in place to deal with this issue and they rely on their clinical background and skills. According to these staff members, they recently have the ability to refer to a nurse practitioner to assess and possibly initiate treatment. Interview with the DOC revealed there is no policy or procedure regarding this. Interview with the RD revealed he/she has not been approached by the home to develop any policies. Interview with the DOC confirmed the home's nutrition and hydration policy was incomplete and needed to be revised.

2. Record review and interview with family member #201 revealed that resident

#043's health condition had been deteriorating since the resident had a fall on a specified date, and the resident had a history of an identified health condition.

Review of resident #043's progress notes revealed that on a specified date, a nurse practitioner recommended treatment for three days for an identified health condition. Registered staff later documented that the resident was consistently eating poorly over a specified time period.

Interviews on a specified date with registered staff #121, nurse manager #123 and DOC confirmed that resident #043's health condition had changed in the specified period. According to registered staff #121, a three day food record had not been initiated because nursing staff did not receive the sheets from the dietary department and nursing had not referred the resident to the dietitian since a specified date. On an identified date, after the inspector inquired about the possibility of changed health condition due to poor intake and no relevant specific intake documentation, nurse manager #123 initiated a fluid intake and output sheet and notified a nurse practitioner. Interview with the DOC had already confirmed that the home needs to improve their identified program to give staff clear direction on how to identify those at risk and implement interventions to mitigate and manage the risks.[s. 68. (2) (a)]

(501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2016

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA s.19(1) to ensure that residents are protected from abuse by anyone in the home.

The plan must include:
• A process to monitor interactions between staff and residents to ensure residents' rights to be protected from abuse is fully respected and promoted.
• A system to ensure that all newly hired staff have clear criminal reference checks before the start of employment and such checks are conducted within six months before the staff members are hired.
• A process to ensure that every alleged, suspected or witnessed neglect of a resident by the licensee or staff that the licensee knows of, or that is reported is immediately investigated.
• A method to monitor the call bell system to ensure residents are provided assistance in a timely manner.

The plan is to be emailed to Susan.Semeredy@ontario.ca on or before December 15, 2015.

Grounds / Motifs :

1. Section 19. (1) of the LTCHA, 2007, was issued as a written notification and voluntary plan of correction as part of the Resident Quality Inspection (RQI) #2014_321501_0016 report dated November 26, 2014.

Due to the actual risk to residents as well as the above mentioned history of non-compliance, the following is been issued as an order:

The licensee has failed to ensure that residents are protected from abuse by anyone in the home.

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

Review of a critical incident report revealed a witnessed incident of staff to resident verbal abuse occurred on specified date at the home. On identified date and time, the resident was entering the dining room for breakfast and saw PSW staff #127 and commented that he/she had been waiting for the PSW for a long time. The resident demanded care services from the PSW. The PSW became angry and argued with the resident to the point of yelling at the resident in front of the other residents and staff. Another PSW intervened and removed the identified PSW from the dining room.

The incident was reported to the executive director (ED) who initiated an investigation. Meetings were called for the staff present at the dining room to meet with the ED and gave their account of the incident verbally. Following the investigation it was deemed that PSW staff #127 had been verbally abusive to the resident and his/her employment was terminated. The DOC submitted a critical incident report on specified date and time to the Ministry of Health & Long Term Care (MOHLTC).

The inspector conducted interviews with RPN staff #121, #137, and PSW staff #130 who had witnessed the abuse incident. The PSW staff #127 was witnessed to have a heated verbal exchange with the resident and was using profanities. The PSW staff #127 was escorted out of the dining room by PSW staff #146. While on his/her way out, the PSW staff #127 was observed to be still looking back at the resident in an angry manner. Interview with RPN staff #137 revealed he/she had previously witnessed PSW #127 speaking to the same resident in an abusive tone using profanities. RPN staff #137 stated that he/she did not report this abuse to anyone and was unable to provide a specific date.

Interview with the DOC and ED confirmed the incident of staff to resident verbal abuse did occur to resident #044 on the above mentioned date and time. (600)

2. Review of a critical incident report submitted by the home on a specified date and time revealed a suspected incident of staff to resident verbal abuse occurred to resident #045. The report revealed the resident was dependent on staff's assistance for activities of daily living. The resident was in his/her room and rang the call bell to have his/her brief changed. PSW staff #128 entered the room and said to the resident in a loud voice, "why are you calling me? I have things to do". The conversation was overheard by MOHLTC inspector #501. PSW staff #128 was interviewed by inspector #501 at the time and the PSW indicated that he/she has a hearing problem and that was the reason for speaking loudly to the resident. When asked why he/she was speaking to the resident in a scolding tone, the PSW expressed remorse, apologized and told the inspector that she/he would not do that again.

The inspector brought the incident to the attention of nurse manager #123. An investigation was initiated and PSW staff #128 was suspended for the day. Upon return to work, the PSW was re-educated on Residents' Bill of Rights and the home's abuse policy. The PSW continued to provide care to the residents on the same unit.

Interview with the resident revealed the resident could recall the incident, however did not know the name of the staff who talked loudly. The resident stated that he/she did not report the incident to anyone at the home but now knows he/she could talk to the nurses.

Interview with the DOC confirmed that the staff to resident verbal abuse did occur to the resident on the above mentioned date and time.
(600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 23rd day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gordana Krstevska

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