Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 31, 2017	2017_575214_0006	006487-17	Resident Quality Inspection

Licensee/Titulaire de permis

MARYBAN HOLDINGS LTD
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

OAKWOOD PARK LODGE
6747 OAKWOOD DRIVE NIAGARA FALLS ON L2E 6S5

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

CATHY FEDIASH (214), KELLY HAYES (583), ROSEANNE WESTERN (508), THERESA MCMILLAN (526)

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): March 29, 30, 31, April 4, 5, 6, 7, 10, 11, 12, 13, 18, 19, 20 and 21, 2017.

The following onsite Inquiries were conducted concurrently with the RQI: 000990-17; 035241-16; 028106-16; 006175-17; 032206-16; 023565-16; 009587-16; 008127-17 related to allegations of abuse and neglect; 028036-15 related to allegations of missing medications; 000367-17 related to reporting and complaints and transfer and positioning; 006351-17 related to falls management.

The following Critical Incident inspections were conducted concurrently with the RQI: 003945-16; 014903-16; 018391-16; 020265-16; 030249-16; 034005-16; 034973-16; 002421-17 related to allegations of abuse and neglect; 016958-16; 019809-16; 033776-16; 034609-16 related to falls prevention; 020429-16 related to medication management and safe storage of drugs.

The following complaint inspections were conducted concurrently with this RQI: 002412-17 related to prevention of abuse and neglect; falls prevention and use of restraints and personal assistance services device; 020862-16; 006752-17; 008054-17 related to prevention of abuse and neglect.

The following follow up inspections were conducted concurrently with this RQI: 028088-16 related to complying with the home's referral to the Registered Dietitian policy; 028089-16 related to repositioning of residents.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC); Assistant Director of Care (ADOC); Director of Therapeutic Recreation Services (DTRS); Food Service Nutrition Manager (FSNM); Registered Dietitian (RD); Resident Assessment Instrument (RAI) Coordinator; registered staff; Personal Support Workers (PSW); President of Residents' Council; residents and families. During the course of the inspection, the Inspectors toured the home; reviewed resident health records; reviewed meeting minutes; reviewed policies and procedures; reviewed Critical Incident System (CIS) submissions; observed residents and the administration of medications.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 50. (2)	CO #002	2016_248214_0014	508
O.Reg 79/10 s. 8. (1)	CO #001	2016_248214_0014	214

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, when a resident was restrained by a physical device, that the physical device was applied in accordance with the manufacturer's instructions.

Review of the vendor's manufacturer's instruction sheets and the home's education material for staff indicated that staff were instructed to apply identified physical devices as follows:

"'Posey' Lapbelt/Padded Lap belt Application instructions": "Adjust the tightness of the slide buckles. Check that the straps are secure and will not change position, loosen, or tighten if the patient pulls on them, or if the chair is adjusted...The belt must be snug, but not interfere with breathing. To check for proper fit, slide an open hand (flat) between the belt and the patient."

"Belt Application for Proper Positioning": "To be effective, any belt must be: positioned across the hips; not across the abdomen; not too loose to allow client to slide under belt, nor too tight to irritate bony prominences or soft tissue. (Just enough space for two fingers to fit between the belt and pelvic crest)."

"Wheelchair Safety Positioning and Transportation" power point slides: "Must be snug to position client, but not so tight to cause injury, not too loose to allow client to slide under belt. Do your fingers fit snugly between the belt and the client? Difficult to get fingers in between? - Seatbelt is too tight! Gap between your fingers and belt - Seatbelt is too loose!!"

During a tour of the home on an identified date, seven identified residents were observed to have identified physical devices in place on their mobility devices. The physical devices were applied loosely. There was a gap between the physical device and the resident of three to six inches. During an interview with an identified staff member, it was confirmed that all seven identified residents were unable to undo their physical device. The staff confirmed that they were loose and not applied according to the manufacturer's instructions since they could place more than just their hand between the physical device and the resident. They reported that they instructed front line nursing staff to adjust the physical device according to manufacturer's instructions and audited the completion of this task prior to 1400 hours.

During an interview, the DOC confirmed that physical devices applied between three and six inches between the device and the resident as noted above, were not applied according to manufacturer's instructions. [s. 110. (1) 1.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A review of resident #022's plan of care dated on an identified date in 2016, indicated that staff were to seat resident #022 in their mobility device with an identified physical device when the resident demonstrated an identified responsive behaviour in order to minimize the risk of falling.

Further review of the resident's clinical record indicated that a quarterly safety assessment had been completed on an identified date in 2016, which identified the resident as a high risk for falls.

Under section "G" of this assessment, the assessment indicated that a Personal Assistive Safety Device (PASD) was assessed as an intervention to decrease the risk of falling.

It was confirmed through review of the resident's clinical record and during an interview with the ADOC that the care set out in the plan of care was not based on an assessment of the resident and the needs and preferences of that resident.

PLEASE NOTE: This area of non-compliance was identified during a complaint inspection, log #002412-17, conducted concurrently during this RQI. [s. 6. (2)]

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

Resident #022 had a history of identified responsive behaviours. During a review of the resident's current plan of care for responsive behaviours that staff refer to for direction, it was identified that the home had implemented an identified intervention to monitor the resident's wherabouts.

During an interview with the DOC, the DOC indicated that the intervention had been discontinued; however, the plan of care had not been updated.

It was confirmed during review of the resident's clinical record and during an interview with the DOC that the resident was not reassessed and the plan of care reviewed and revised at least every six months or when care set out in the plan was no longer necessary.

PLEASE NOTE: This area of non-compliance was identified during a complaint inspection, log #02414-17, conducted concurrently during this RQI. [s. 6. (10) (b)]

3. The licensee failed to ensure that when a resident was reassessed and the plan of care was reviewed and revised when the care set out in the plan was not effective, that different approaches were considered in the revision of the plan of care.

A) A review of resident #006's nutrition plan of care identified they were assessed to be a high nutrition risk. The resident had an identified weight on a date in 2017 that was 7.9 kilograms (kg) below the lowest weight of their assessed goal weight range.

On an identified date in 2016, a referral was received by the dietary department for the resident for low food intake (resident ate less than 75 per cent of their food for 15 out of 21 meals over a seven day period), as directed in the home's nutrition and hydration

program policies and procedures. The resident was assessed by the RD and no changes were made to their nutritional plan of care. At this time the RD put in place a new referral parameter for the resident's food intake.

On a later identified date in 2016, a referral was received by the dietary department for the resident for low food intake (resident ate less than 75 per cent of their food for 15 out of 21 meals over a seven day period), as directed in the homes nutrition and hydration program policies and procedures. An assessment was not completed by the RD. In an interview with the RD on an identified date in 2017, it was confirmed that the referral was declined because the resident did not meet the new referral parameter for food intake.

On an identified date in 2016 and 2017, a quarterly nutrition assessment was completed by the RD which indicated that the resident continued to have non-significant weight loss over the previous six month period and remained at high nutrition risk. No changes were made when the nutrition plan of care was reviewed during the resident's two quarterly nutrition assessments.

In an interview on an identified date in 2017, the RD confirmed that there were no documented changes to the nutrition plan of care over the nine month period. It was confirmed that different approaches were not considered in the revision of the plan of care when current interventions had not been effective in improving the resident's nutritional status.

B) A review of resident #070's nutrition plan of care identified they were assessed to be at high nutrition risk; had a history of poor food and fluid intake and were noted to have a nine percent (%) gradual weight loss over an identified period of six months. The resident had an identified weight on a date in 2017 that was 3 kg below the lowest weight of their assessed goal weight range.

Referrals were made to the RD for resident #070, on four identified dates in 2016, as directed in the home's nutrition and hydration program policies and procedures for low food and fluid intake as well as refusal of their identified daily supplement that was put into place prior, for poor intake.

Following the last referral, the RD put in place a new referral parameter for fluid intake for the resident and the resident's identified supplement was discontinued. At this time no new interventions were trialled to improve resident #070's food and fluid intake and no interventions were trialled in relation to the residents previous supplement refusal.

On an identified date following the new referral parameter being put into place a referral was received by the dietary department for the resident for low fluid intake as directed in the home's nutrition and hydration program policies and procedures. An assessment was not completed by the RD. In an interview with the RD on an identified date in 2017, it was confirmed that the referral was declined because the resident did not meet the new referral parameter that had been put into place.

In an interview with the RD, it was confirmed that there were no documented changes to the nutrition plan of care since the resident's admission nutrition assessment on an identified date in 2016. It was confirmed that different approaches were not considered in the revision of the plan of care when current interventions had not been effective in preventing a decline to the resident's nutritional status.

C) A review of resident #020's nutrition plan of care identified they were assessed to be at high nutrition risk and a history of poor food and fluid intake and were noted to have a nine percent gradual weight loss over six months. The resident had an identified weight on a date in 2017 that was 23.4 kg below the lowest weight of their ideal body weight range.

On an identified date in 2016, a referral was received by the dietary department for resident #020 for low food intake as directed in the home's nutrition and hydration program policies and procedures. The resident was assessed by the RD and no new interventions were trialled at that time. At this time the RD put in place a new food and fluid referral parameter that identified when resident #020 should be referred.

On two identified dates in 2016 and one identified date in 2017, a quarterly nutrition assessment was completed by the RD. It was documented that the resident continued to be at high nutrition risk with an ongoing decline in nutritional status. No new nutrition interventions were trialled at the three quarterly assessments.

An RD assessment completed on an identified date in 2016, identified resident #020 was on an identified daily supplement and indicated that a further increase would not be trialled based on their previous refusals. In an interview with registered staff #300 on an identified date in 2017, they shared the resident usually takes the supplement well, typical 100 per cent.

In an interview with the RD it was confirmed as per the documented assessments, a new

nutrition intervention was last trialled for resident #020 on an identified date in late 2015. A review of resident #020's weights show that their weight had decreased 6.3 kg over an identified period of approximately 15 months. It was confirmed that different approaches were not considered in the revision of the plan of care when current interventions had not been effective in improving resident #020's nutritional status. [s. 6. (11) (b)]

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. The licensee failed to ensure that the nutrition care and dietary services and hydration program policies and procedures, relating to the system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration were implemented.

A review of the "Dietary Referral Process for Documented Food Intake < 75% and Fluid Intake < 1000 ml per Day", dated with an identified date in 2017, identified nursing staff were to make a referral to the RD when:

i) a resident ate less than 75 per cent of their food for 15 out of 21 meals over a seven day period
ii) a resident refused to eat for more than three days
iii) a residents fluid intake was less than 1000 ml per day for five days in a row

For residents that did not require 1000 ml per day of total fluids the procedure identified that a different parameter to trigger a referral for low fluid intake would be set by the Food Service Nutrition Manager (FSNM) or the RD and communicated on the resident's flow sheet.

A review of the "RD referrals for poor food or fluid intake" record, provided by the FSNM on an identified date in 2017, identified that 54 residents were put on lower parameters to trigger a referral to the RD for low food and fluid intake than directed by the home's procedure. The 54 residents identified on the record were at moderate or high nutrition risk and had a history of poor food or fluid intake.

It was identified nursing staff were to make a referral to the RD for low food intake when:

i) a resident ate less than 50 per cent of their food for 15 out of 21 meals over a seven day period – put in place for 17 residents
ii) a resident had no food intake for three days in a row – put in place for 19 residents

It was identified nursing staff were to make a referral to the RD for low fluid intake when:

i) fluid intake was less than 800 ml per day for five days in a row – put in place for three residents
ii) fluid intake was less than 750 ml per day for five days in a row – put in place for four residents
iii) fluid intake was less than 700 ml per day for five days in a row – put in place for four residents
iv) fluid intake was less than 650 ml per day for five days in a row – put in place for three residents
v) fluid intake was less than 625 ml per day for five days in a row – put in place for one

resident
vi) fluid intake was less than 600 ml per day for five days in a row – put in place for four residents
vii) fluid intake was less than 575 ml per day for five days in a row – put in place for three residents
viii) fluid intake was less than 550 ml per day for five days in a row – put in place for two residents
ix) fluid intake was less than 500 ml per day for five days in a row – put in place for seven residents
x) fluid intake was less than 475 ml per day for five days in a row – put in place for one resident
xi) fluid intake was less than 450 ml per day for five days in a row – put in place for two residents
xii) fluid intake was less than 400 ml per day for five days in a row – put in place for two residents
xiii) fluid intake was less than 300 ml per day for five days in a row – put in place for one resident
xiv) fluid intake was 0 ml per day for a three days in a row – put in place for one resident

The "Hydration Management" (CD-05-12-1) policy provided suggested methods to use when calculating estimated fluid needs. According to the homes policy one resident out of 38 residents put on lower fluid parameter to trigger an RD referral may have required less than 1000 ml per day. The identified resident had been placed on a parameter of having zero ml per day for three days in a row before a referral would be sent to the RD.

The Administrator and the RD were interviewed about the home's system to monitor and evaluate the food and fluid intake of residents with identified risks. It was confirmed that there was no procedure or policy developed or implemented for the homes new practice of setting different parameters to trigger a low food and fluid intake for 54 residents identified. It was confirmed that the policies and procedures related to nutrition and hydration were not implemented as directed in the homes nutrition care and hydration program. [s. 68. (2) (a)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 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 failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were 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.

A) A review of resident #018's clinical record indicated that on an identified date in 2017, the resident had an identified weight loss of 7.4 % over an identified period of one month; a 9.9 % weight loss over an identified period of three months and a 12.3% weight loss over an identified period of 6 months.

A review of the resident's clinical record indicated that no assessment had been completed when the resident sustained a weight change for an identified time period of more than 5 % over one month; more than 7.5 % over three months and more than 10 % over 6 months. An interview with the RD confirmed that the resident had not been assessed when they demonstrated the identified weight changes.

B) A review of resident #047's nutrition plan of care identified they were assessed to be at high nutrition risk.

On an identified date in 2016, resident #047's identified weight triggered a significant weight change of 5 per cent of body weight, or more in one month; a change of 7.5 per

cent of body weight or more, over three months and a change of 10 per cent of body weight.

On an identified date in 2017, resident #047's identified weight triggered a significant weight change of 5 per cent of body weight, or more in one month; a change of 7.5 per cent of body weight in or more, over three months; a change of 10 per cent of body weight.

A review of resident #047's progress notes identified that the resident's significant weight changes were not assessed by the RD using a multidisciplinary approach. A review of the documented nutrition assessments completed for an identified period of approximately one year identified that no actions had been taken. One change was documented on an identified date in 2016 which identified that the resident's identified supplement was decreased by 40 ml daily.

In an interview with the RD it was shared that the home did not have a monitoring process in place to identify when residents had a significant weight change. It was confirmed with the RD that the resident's significant weight changes on three identified months were not assessed using an interdisciplinary approach, and actions were not taken. (Inspector #583)

C) A review of resident #070's nutrition plan of care identified they were assessed to be at high nutrition risk and had a history of poor food and fluid intake.

A review of the clinical record indicated that over an identified period of time, resident #070's had a gradual weight loss of nine per cent over six months. On an identified date in 2017, the resident's weight fell below their ideal body weight range (IBWR) and continued to decline over the next two months.

A review of the progress notes identified that resident was last assessed by the RD on an identified date in 2017. It was noted that the resident had not been assessed when their weight fell below an IBWR and continued to decline by the RD using a multidisciplinary approach.

In an interview with the RD it was shared that the home did not have a monitoring process in place to identify when resident's had weight changes that compromised their health status. It was confirmed that resident #070's had not received a nutrition assessment in greater than four months, that their weight change was not assessed

using an interdisciplinary approach and actions were not taken. (Inspector #583) [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) On an identified date in 2017, staff #138 was providing care to resident #027 when resident #027 made a comment to the staff member which frustrated the staff causing the staff member to leave the room. When the staff member returned to the room, they made a comment to the resident that was witnessed by another resident. The comment was degrading and upset the resident.

Staff #138 knew that they had been verbally abusive to the resident and immediately reported the incident to the Registered Nurse. The home responded to the incident and support was provided to the resident.

It was confirmed during an interview with the Administrator that resident #027 was not protected from abuse by anyone.

PLEASE NOTE: This non compliance was identified during a complaint inspection, log #020862-16, conducted concurrently during this RQI.

B) On an identified date in 2016, it was witnessed by staff #264 that resident #023 grabbed the hand of resident #022 and then resident #023 touched resident #022's in an

identified area. Staff #264 immediately intervened and separated the two residents and reported the incident to the registered nurse.

Resident #022 was incapable of consenting to the identified actions of resident #023. During an interview with staff #264 on an identified date the staff confirmed that the incident was non-consensual. Documentation also confirmed that the resident was incapable of providing consent to the actions by resident #023.

It was confirmed that the licensee failed to ensure that resident #022 was protected from abuse by anyone.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection, log #030249-16, conducted concurrently during this RQI.

C) On an identified date in 2016, resident #029 reported to staff that resident #033 grabbed them in an identified area without their consent. Resident #033 had known responsive behaviours towards co-residents and staff.

It was confirmed during review of the resident's clinical record and during an interview with the Administrator that resident #029 was not protected from abuse by resident #033.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection, log #014903-16, conducted concurrently during this RQI.

D) On an identified date in 2016, it was witnessed by staff that resident #033 was touching resident #034 on an identified area. Resident #033 had known responsive behaviours towards co-residents and staff.

It was confirmed during a review of the resident's clinical record that they were unable to consent. An interview with the Administrator confirmed that resident #034 was not protected from abuse by anyone.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection, log # 018391-16, conducted concurrently during this RQI.

The licensee failed to ensure that residents were not neglected by the licensee or staff.

A) The following residents were not assessed using an interdisciplinary approach, and

actions were not taken and outcomes were not evaluated when they had a significant weight change or any other weight change that compromised their health status.

i) In an interview with the RD on an identified date in 2017, it was confirmed that resident #047's significant weight changes over three identified months were not assessed using an interdisciplinary approach, and actions were not taken. Resident #047 was assessed to be at high nutrition risk. During this 12 month period the resident had a 12 % weight loss and their weight fell below their IBWR.

ii) In an interview with the RD on an identified date in 2017, it was confirmed resident #070's weight change that compromised their health status, was not assessed. Resident #070 was assessed to be at high nutrition risk. On an identified date in 2017, resident #070's weight fell below their IBWR and continued to decline over the next two months, resulting in a 10% weight loss in six months.

In an interview with the RD it was shared that the home did not have a monitoring process in place to identify when residents had a significant weight change or any other weight change that compromised the resident's health status.

B) When the following resident's nutrition plans of care were reassessed and the plans of care were reviewed and revised when the care set out in the plans were not effective, different approaches were not considered in the revision of the plans of care.

i) Resident #006 was referred to the RD on an identified date in 2016, for low food intake and again seven days later for low food intake. On identified dates in 2016 and 2017, quarterly nutrition assessments were completed by the RD. It was documented that the resident continued to have non-significant weight loss over the previous six month period; remained underweight with an identified low BMI; had ongoing variable intake and remained at high nutrition risk.

In an interview on an identified date in 2017, with the RD, it was confirmed that there were no documented changes to the nutrition plan of care over the nine month period. It was confirmed that different approaches were not considered in the revision of the plan of care when current interventions had not been effective in improving resident #006's nutritional status.

ii) Resident #070 was referred to the RD on two identified dates, which were two days apart, in 2016, for low food intake. The resident was referred 12 days later for low fluid

intake and declining supplements. The resident was referred to the RD one day later for low fluid intake. It was documented that the resident was at high nutrition risk; had a history of poor food and fluid intake and was noted to have a nine % gradual weight loss over six months in which their weight fell below their IBWR.

In an interview on an identified date in 2017, with the RD, it was confirmed that there were no documented changes to the nutrition plan of care since resident #070's identified nutrition assessment, approximately seven months prior. It was confirmed that different approaches were not considered in the revision of the plan of care when current interventions had not been effective in preventing a decline to resident #070's nutritional status.

iii) Resident #020 was referred to the RD on an identified date in 2016, for low food intake. On two identified dates in 2016 and one identified date in 2017, quarterly nutrition assessments were completed by the RD. It was documented that the resident was at high nutrition risk; severely underweight and a history of poor food and fluid intake and were noted to have a nine % gradual weight loss over six months. On an identified date in 2017, resident #020's weight was 23.4 kg below the lowest weight of their ideal body weight range.

In an interview with the RD on an identified date in 2017, it was confirmed as per the documented assessments, a new nutrition intervention was last trialled for resident #020 on an identified date in 2015. A review of the resident's clinical record showed that the resident's weight had decreased 6.3 kg over an identified period of approximately 15 months. It was confirmed that different approaches were not considered in the revision of the plan of care when current interventions had not been effective in improving resident #020's nutritional status.

C) The licensee failed to ensure that the nutrition care and dietary services and hydration program policies and procedures relating to the system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration were implemented.
A review of the "Dietary Referral Process for Documented Food Intake < 75% and Fluid Intake < 1000 ml per Day", dated January 2017, identified nursing staff were to make a referral to the RD when:

i) a resident ate less than 75 per cent of their food for 15 out of 21 meals over a seven day period

ii) a resident refused to eat for more than three days
iii) a residents fluid intake was less than 1000 ml per day for five days in a row

For residents that did not require 1000 ml per day of total fluids, the procedure identified a different parameter to trigger a referral for low fluid intake which would be set by the FSNM or the RD and communicated on the resident's flow sheet.

A review of the "RD referrals for poor food or fluid intake" record, provided by the FSNM on an identified date in 2017, identified that 54 residents were put on lower parameters to trigger a referral to the RD for low food and fluid intake than directed by the homes procedure. The 54 residents identified on the record were at moderate or high nutrition risk and had a history of poor food or fluid intake.

In an interview with the RD on an identified date in 2017, they were asked to share why residents were put on lower parameters to trigger a low fluid or food intake referral than directed in the homes policy. It was shared that the home was having difficulty managing the number of referrals when the system was implemented. The RD shared they re-calculated the parameters to reduce the amount of referrals to an "appropriate amount of referrals". In an interview with the Administrator it was confirmed they were aware to the changes in the referral process to the RD.

D) The registered dietitian who was not on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties during the time period reviewed.

The home had a bed capacity of 153 residents. The hours that the RD was required to complete monthly based on 30 minutes per resident was 76.5 hours. This was confirmed with the Administrator on an identified date in 2017.

In an interview with the RD on an identified date in 2017, it was confirmed that out of the required 76.5 hours per month required to be completed on site at the home only 51 hours were completed in one identified month, 46 hours in the following month and 50.5 hours in the identified month following. It was confirmed with the Administrator that the required 76.5 monthly RD hours to carry out clinical and nutrition care duties were not completed on site.

The lack of action taken to address residents who demonstrated weight loss; lack of different approaches considered in the revision of the resident's plan of care to improve

their nutritional status related to weight loss; the lack of ensuring that the home's policies and procedures were implemented related to monitoring and evaluating resident's with identified nutrition and hydration risks and not ensuring that the registered dietitian was on site at the home for a minimum of 30 minutes per resident per month, demonstrated that residents who were at a high nutrition risk were not provided with the nutritional care required for health and well-being, showing a pattern of inaction that jeopardizes the health and well-being of one or more residents. (Inspector 583) [s. 19. (1)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During the initial tour of the home between two identified hallways, LTC Homes Inspector #526 observed a green light on the security panel on the wall near an entrance door that led to a vestibule and an outside door that led to the parking lot. Both doors were unlocked and the LTC Homes Inspector could open both doors which led to the outside parking lot. Residents were observed ambulating in and around the area. Within a minute of this observation, registered staff #201 observed that the doors were unlocked and indicated they did not know how long the door had been opened and were not aware if any residents had left through the door. They confirmed that the doors should have been locked and proceeded to set the code at the panel (making the light red) so that the doors were locked and closed. During an interview, Registered staff #201 and the DOC confirmed that doors leading to the outside of the home should be closed and locked at all times. [s. 9. (1) 1. i.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to are kept closed and locked, to be implemented voluntarily.

WN #7: 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:
19. Safety risks. 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 failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 19. Safety risks.

A CIS submitted by the home indicated that on an identified date in 2016, resident #045 sustained a fall in which they were transferred to hospital with an identified injury.

A review of the resident's written care plan indicated that on an identified date in 2016, the resident had been identified under their risk for falls as now being a high risk. A review of the Safety Assessment fall, restraint & bed rail-V4 assessment that is completed in Point Click Care (PCC) and identifies the resident's level of fall risk, indicated that this assessment was last completed a little over one month prior at which time the resident was assessed to be a medium fall risk. No Safety Assessment fall, restraint & bed rail-V4 assessment could be located. An interview with the DOC confirmed that a Safety Assessment fall, restraint & bedrail-V4 assessment was to be completed with any significant change in condition that impacts fall risk and that the resident's plan of care in relation to their level of fall risk was not based on an interdisciplinary assessment.

PLEASE NOTE: This non-compliance was issued as a result of a Critical Incident System Inspection #019809-16 that was conducted concurrently with the RQI Inspection. [s. 26. (3) 19.]

2. The licensee failed to ensure that the Registered Dietitian completed a nutritional assessment on the resident's nutritional status, including height, weight and any risks relating to nutrition care, whenever there was a significant change in the resident's health condition.

A review of resident #070's nutrition plan of care identified they were assessed to be at high nutrition risk; had a history of poor food and fluid intake and were noted to have an identified gradual weight loss over six months. On an identified date in 2017, the resident's weight was documented to be below the lowest weight for their IBWR.

On an identified date in 2016, the resident was assessed by the FSNM as the resident had been referred to the RD for low food intake. It was documented that the RD was to follow up.

Twelve days later, the RD discontinued the resident's identified supplement as a dietary referral was received notifying the RD the resident was declining the supplement.

A review of the resident's progress notes identified an assessment of the resident's low food intake was not completed and when the resident's identified supplement was discontinued, the resident was not reassessed when the plan of care was not effective.

In an interview with the RD on an identified date in 2017, it was confirmed that resident #070's risks related to nutrition care were not assessed in relation to their prior referrals. [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 Registered Dietitian completes a nutritional assessment on the resident's nutritional status, including height, weight and any risks relating to nutrition care, whenever there is a significant change in the resident's health condition, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to minimize the restraining of residents was complied with.

A review of the home's Restraint policy, #CN-R-05, with a review date of February, 2016, under the section titled "Requirements that must be in plan of care prior to physical restraint use", directed staff that the restraining of a resident was only included in the resident's plan only if all the following were satisfied:

1. There was significant risk that the resident or another person would suffer serious bodily harm if the resident was not restrained. The details of the risk must be included on the care plan.

2. Alternative to restraining the resident were considered, and tried where appropriate, but would not be, or had not been effective to address the risk. The restraint assessment must be completed detailing alternatives tried and alternatives included on the care plan.

3. The method of restraining was reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable methods that would be effective to address the risk.

4. A physician or registered nurse in the extended class has ordered the restraint. The order must clearly indicate the type of restraint, when and where it was to be used, the detailed reason for use and any special instructions for use. The order is included on the care plan.

5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

6. Consent must be documented in the progress notes and the consent form signed. (see section on obtaining consent)

7. The plan of care documents everything included in 1 through 5.

On two identified dates in 2017, staff placed on resident #022, a identified physical device. It was witnessed by a visitor and confirmed by registered staff #225 and #229 that staff applied the identified physical device on the resident without meeting the requirements as described in the policy.
It was confirmed during an interview with the ADOC on an identified date in 2017, that staff failed to comply with the home's Restraint policy.

PLEASE NOTE: This area of non-compliance was identified during a complaint inspection, log #002412-17, conducted concurrently during this RQI. [s. 29. (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 written policy to minimize the restraining of residents is complied with, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident of the home was restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

Resident #022 had a known diagnoses and exhibited identified responsive behaviours. A review of the resident's plan of care in place for an identified period in 2017, indicated that interventions in the plan included increased monitoring of the resident and for an identified reason, an identified physical device was to be applied.

On several occasions it was witnessed by a visitor that resident #022 was observed with an identified physical device in place. The resident was not able to reach to undo the physical device. Documentation in the resident's clinical record confirmed that on two identified dates in 2017, the visitor had expressed concerns to registered staff #225 and staff #229 and the staff documented the concerns on these identified dates.

It was confirmed through documentation and during interviews with staff #225 that the home did not ensure that a resident was not restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

PLEASE NOTE: This area of non-compliance was identified during a complaint inspection, log #002412-17, conducted concurrently during this Resident Quality Inspection. [s. 30. (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 no resident of the home is restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions with respect to a resident under a program, including reassessments were documented.

In an identified assessment completed by the RD on an identified date in 2016, resident #070's goal weight range was assessed with an identified weight range and an identified BMI range based on an identified height measured in centimetres (cm) . The current goal weight documented in the "Weight Summary" section in PCC showed the goal weight range for resident #070 was changed to a lower identified goal weight range; a lower BMI and based on a height that was 4 cm lower than previously assessed.

The home's Nutrition/Hydration Risk Identification Tool Policy (CD-06-11-1.1), provided direction for determining healthy weight ranges, identifying a BMI of 24 to 29 is considered healthy weight for most elderly.

In an interview with the RD on an identified date in 2017, it was confirmed that there was no documented reassessment of resident #070 that identified when and why a new goal weight was established and it was confirmed that there was no documented reassessment of the resident's height to identify which was correct. [s. 30. (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 any actions with respect to a resident under a program, including reassessments are documented, 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 failed to ensure that when a resident exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments.

Resident #022 had an identified alteration to their skin integrity which was identified by a family member on an identified date in 2017. The resident was unable to identify how the alteration to their skin integrity occurred.

A review of the resident's clinical record indicated that registered staff #229 documented in a progress note that on an identified date in 2017, staff had also identified that the resident had the alteration to their skin integrity. A skin assessment using a clinical appropriate assessment instrument had not been completed.

It was confirmed during a review of the resident's clinical record that when it was identified that the resident exhibited altered skin integrity, the resident was not assessed by a member of the registered nursing staff using a clinically appropriate assessment instrument.

PLEASE NOTE: This area of non-compliance was identified during a complaint inspection, log #002414-17, conducted concurrently during this RQI. [s. 50. (2) (b) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the resident 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 assessments, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #007 was admitted to the home on an identified date at which time they had three identified areas of altered skin integrity and identified responsive behaviours. During a care conference on an identified date it was noted that pain may be a contributing factor to their responsive behaviours. A review of progress notes revealed that the identified behaviours continued and were documented at least 45 times between an identified period of approximately five weeks. Review of the plan of care and interview with registered staff #215 confirmed that resident #007 was receiving an identified routine analgesic and had an identified as needed (PRN) analgesic prescribed and administered. They were administered the identified PRN analgesic on six identified dates. Review of the home's documentation indicated that the pain and effectiveness of the identified PRN analgesic on four identified dates, had not been assessed. A review of their plan of care indicated that it did not include non-pharmaceutical interventions for pain.

The home's "Pain Management" Policy number CN-P-09-1 dated January 2016 directed staff "For residents who have pain and receive prn pain medication, a PACSLAC (Pain Assessment Checklist for Seniors with Limited Ability to Communicate) or if cognitive, the cognitive pain assessment in Point Click Care (PCC) is completed". This policy was confirmed as being in effect by the DOC, in that staff should have assessed resident #007's pain using the identified appropriate pain assessment instrument when they were observed as requiring additional pain medication. During interview, registered staff #215 and #225 and the DOC confirmed that when resident #007's pain was not relieved by regularly scheduled analgesia, their pain was not assessed using a clinically appropriate assessment instrument that was specifically designed for this purpose according to the home's policy and legislative requirements.

PLEASE NOTE: This non-compliance was issued as a result of a Complaint Inspection #006752-17, that was conducted concurrently with the RQI Inspection. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, 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 failed to ensure that, for each resident who demonstrated responsive behaviours, (a) the behavioural triggers for the resident were identified, where possible; (b) strategies were developed and implemented to respond to these behaviours, where possible; and (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Resident #007 was admitted to the home from hospital on an identified date. Review of health records indicated that they had an identified Cognitive Performance Score (CPS), had identified skin alterations to three areas on their body, required an identified level of assistance with activities of daily living, ambulated with an identified mobility device with

an identified physical device in place. A review of clinical records indicated that they had exhibited identified responsive behaviours which had diminished following the initiation of an identified prescription. Upon admission to the home, their medication regime was changed and two identified prescriptions were discontinued.

According to documentation in the clinical record, on an identified date in 2017, the resident demonstrated identified responsive behaviours since admission. The documentation suggested that some of the resident's behaviours may have been related to pain due to their altered skin integrity. They were administered an identified analgesic for a specified period of time as needed, which was changed on an identified date to a routine analgesic. The resident's pain was assessed three times on identified dates using an identified pain assessment checklist scale. They were administered an identified PRN analgesic on three identified dates. During interview, registered staff #225 stated that pain as a behavioural trigger had not been considered and staff had not routinely assessed the resident's pain despite the potential for pain as noted above.

Review of progress notes revealed that between an identified period of approximately five weeks, resident #007's behaviours escalated revealing that they demonstrated an identified behaviour at least 29 times, another identified behaviour at least 17 times, and a third identified behaviour at least eight times and removed an identified device on four identified occasions. Registered staff #215 and #225 noted that the resident could demonstrate an identified responsive behaviour when using their identified mobility device and would undo an identified physical device causing a change in their positioning. During this inspection, LTC Homes Inspectors observed resident #007 demonstrate identified behaviours which were not easily altered and resulted in co-residents demonstrating identified responsive behaviours toward resident #007.

Resident #007's behaviours were reviewed by the home's responsive behaviour committee on five identified dates. According to the DOC, no behavioural assessments had been conducted despite the resident's escalating behaviours but that steps to initiate behavioural assessments had taken place since a recent meeting on an identified date. Up to that time, committee recommendations focused on three identified areas and other potential underlying causes of the behaviours had not been determined and pain had not been assessed or identified as a potential trigger. Review of progress notes revealed descriptions of resident #007's behaviours, they did not indicate the identification of situational or other care related triggers. During interview, registered staff #225 and #201 identified possible triggers for the resident's behaviours. Strategies that seemed effective were identified.

The document the home referred to as resident #007's care plan was updated on an identified date and provided identified direction's to staff; however, no interventions in relation to pain management were identified in the plan of care.

The DOC confirmed that resident #007's responsive behaviours had not been assessed and that all potential triggers and strategies to respond to their behaviours had not been considered and/or were not part of the plan of care, or documented.

PLEASE NOTE: This non-compliance was issued as a result of a Complaint Inspection #006752-17, that was conducted concurrently with the RQI Inspection. [s. 53. (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 for each resident who demonstrates responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible; (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's response to interventions are documented, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a registered dietitian who was a member of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

The home had a bed capacity of 153 residents. The hours that the RD was required to complete monthly based on 30 minutes per resident was 76.5 hours. This was confirmed with the Administrator on an identified date in 2017.

A review of the worked RD hours identified the following:

i) For an identified month during an identified year- 51 hours were completed on site at the home and 25.5 hours were completed off site.

ii) The following identified month- 51 hours were completed on site at the home and 30.5 hours were completed off site.

iii) The following identified month - 50.5 hours were completed on site at the home and 26 hours were completed off site

In an interview with the RD on an identified date in 2017, it was confirmed that out of the required 76.5 hours per month required to be completed on site at the home only 51 hours were completed in the first identified month, 46 hours in the next identified month and 50.5 hours in the third identified month. It was confirmed with the Administrator that the required 76.5 monthly RD hours to carry out clinical and nutrition care duties were not completed on site. [s. 74. (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 a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to ensure the advice of the Residents' Council was sought in developing and carrying out the satisfaction survey, and in acting on its results.

Review of the home's Residents' Council meeting minutes over an approximate identified period of one year, indicated that the licensee had not sought the advice of the Residents' Council in the development or carrying out of the 2016 satisfaction survey. This was confirmed during interview with the President of the Residents' Council, the DTRS, and the Administrator. [s. 85. (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 the advice of the Residents' Council is sought in developing and carrying out the satisfaction survey, and in acting on its results, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, when a PASD was used under section 33 of the Act, it was applied by staff in accordance with the manufacturer's instructions (if any).

Review of the vendor's manufacturer's instruction sheets and the home's education material for staff indicated that staff were instructed to apply lap belts to residents as follows:

"'Posey' Lapbelt/Padded Lap belt Application instructions": "Adjust the tightness of the slide buckles. Check that the straps are secure and will not change position, loosen, or tighten if the patient pulls on them, or if the chair is adjusted...The belt must be snug, but not interfere with breathing. To check for proper fit, slide an open hand (flat) between the belt and the patient"

"Belt Application for Proper Positioning": "To be effective, any belt must be: positioned across the hips; not across the abdomen; not too loose to allow client to slide under belt, nor too tight to irritate bony prominences or soft tissue. (Just enough space for two fingers to fit between the belt and pelvic crest)."

"Wheelchair Safety Positioning and Transportation" power point slides:
"Must be snug to position client, but not so tight to cause injury, not too loose to allow client to slide under belt. Do your fingers fit snugly between the belt and the client? Difficult to get fingers in between? - Seatbelt is too tight! Gap between your fingers and belt - Seatbelt is too loose!!

During initial tour of the home on an identified date in 2017 at approximately 1045 hours in an identified area of the home, LTC Homes Inspector #526 observed an identified

physical device to be in use by four identified resident's. The physical devices were applied loosely with between three to six inches between them and the resident. During interview, registered staff #201 confirmed that the physical devices for the four identified residents were used as an identified service device that could not be undone by the resident's; that they were loose and not applied according to the manufacturer's instructions since they could place more than just their hand between the device and the resident. They reported that they instructed staff to adjust the physical device according to manufacturer's instructions and audited the completion of this task prior to 1400 hours.

During interview, the DOC confirmed that the physical devices were not applied according to manufacturer's instructions. [s. 111 (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 when a PASD is used under section 33 of the Act, it is applied by staff in accordance with the manufacturer's instructions (if any), to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

Resident #007's substitute decision maker (SDM) communicated to the Ministry of Health and Long Term Care (MOHLTC) on an identified date in2017, that they believed that the resident had been involved in altercations with co-residents on two separate occasions:

i) on an identified date in 2016, by an unidentified resident who allegedly squeezed an identified area on resident #007, causing injury; and
ii) on an identified date in 2017, by an identified resident who allegedly released an identified physical device and moved the resident to a different position.

Review of resident #007's progress notes and interview with DOC and registered staff #215 indicated that the SDM had complained to the staff in the home regarding the information noted above. The SDM met with the home's DOC on an identified date and then again with the DOC and Administrator later that same week. During interview, the Administrator stated that resident #007's SDM informed them of the information noted above. The home conducted an investigation and the allegation's could not be verified. During interview on an identified date, resident #007's SDM told LTC Homes Inspector #526 that the home had not provided a response to their complaint/allegation of abuse that was made or provided the results of the investigation. When asked if they provided a response to the SDM about this investigation and outcome from police contact, the Administrator stated that they had not, and since there were no further complaints, the Administrator assumed it was resolved.

PLEASE NOTE: This non-compliance was issued as a result of a Complaint Inspection #006752-17, that was conducted concurrently with the RQI Inspection. [s. 97. (2)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that that a documented record was kept in the home that included:

a) the nature of each verbal or written complaint
b) the date the complaint was received
c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
d) the final resolution, if any
e) every date on which any response was provided to the complainant and a description of the response, and
f) any response made by the complainant

Resident #007's SDM communicated to the MOHLTC that they believed that their family member had been involved in altercations with co-residents on two separate occasions:

i) on an identified date in 2016, by an unidentified resident who allegedly squeezed an identified area on resident #007, causing injury; and
ii) on an identified date in 2017, by an identified resident who allegedly released an identified physical device and moved the resident to a different position.

Interview with Registered staff #215 and the DOC indicated that on an identified date, the SDM told the DOC that they thought that resident #007 had been involved in altercations on these occasions and that they were going to notify the police. The SDM then met with the DOC and Administrator later that week to further discuss their concerns. During interview with LTC Homes Inspector #526, the DOC and the Administrator stated that the complaint was investigated and could not be verified. They stated that they did not maintain notes regarding resident #007's SDM's complaint, its investigation, whether it was resolved, or any response to the SDM.

PLEASE NOTE: This non-compliance was issued as a result of a Complaint Inspection #006752-17, that was conducted concurrently with the RQI Inspection. [s. 101. (2)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was:

(a) Documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) Reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A) A review of the home's 'Medication Incident Report' sheets for an identified period of three months in 2017, revealed that there had been an identified number of medication errors. Staff #200 had indicated on an identified date, that a physician's order to decrease a medication for resident #046 had not been transcribed and the resident was receiving a higher dose of the medication for two weeks. This incident had not been reported to the resident's SDM or the resident's attending physician.

B) On an identified date in 2017, staff #220 identified that resident #031 had received a higher dosage of their identified prescription earlier that day. The incident had not been reported to the resident's SDM or the resident's physician.

C) On an identified date in 2017, it was identified by staff #226 that resident #034 had not received their identified scheduled medication the previous evening. This incident had not been reported to the resident's SDM.

It was confirmed during review of the medication incident reports and during an interview with the DOC that these identified incidents had not been reported to the physician or the resident's SDM. [s. 135. (1)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the infection prevention and control program.

A) During a tour of the facility on an identified date in 2017, it was identified that in the Spa Room of an identified unit in the home, a used roll on deodorant was not labelled and stored in this room in an empty water pitcher. In the Shower Room on an identified unit, two sets of nail clippers, a used razor and a used roll on deodorant were stored in this room and all were unlabelled.

During an interview with PSW staff, it was confirmed that these were personal items used by residents and should have been labeled to identify who the items belonged to.

B) During a tour of the home, it was observed in a four bed shared bathroom in an identified room that a urine collection container that was stored on the back of the toilet tank was not labelled. An interview with PSW staff #119 confirmed that they were not aware of which resident the urine collection container was for and that personal items were to be labelled. (Inspector #214) [s. 229. (4)]

Issued on this 18th day of June, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CATHY FEDIASH (214), KELLY HAYES (583), ROSEANNE WESTERN (508), THERESA MCMILLAN (526)
Inspection No. / No de l'inspection :	2017_575214_0006
Log No. / Registre no:	006487-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 31, 2017
Licensee / Titulaire de permis :	MARYBAN HOLDINGS LTD 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	OAKWOOD PARK LODGE 6747 OAKWOOD DRIVE, NIAGARA FALLS, ON, L2E-6S5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Stephen Moran

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

To MARYBAN HOLDINGS LTD, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee shall do the following for residents who have physical devices, including lap belts, that have the effect of limiting or inhibiting a resident's freedom of movement and the resident is not able, either physically or cognitively, to release themselves:

1) Apply the physical device in accordance with the manufacturer's instructions at all times.

2) Retrain direct care staff in relation to application of physical devices, in accordance with manufacturer's instructions.

Grounds / Motifs :

1. This order is based upon three factors where there has been a finding of noncompliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the noncompliance is a widespread (3), the severity of the non-compliance has minimal harm or potential for actual harm (2) and the history of non-compliance under Ontario Regulation 79/10,
r. 110. (1) 1 is ongoing (4) with a CO issued on July 27, 2015.

1. The licensee failed to ensure that, when a resident was restrained by a physical device, that the physical device was applied in accordance with the

manufacturer's instructions.

Review of the vendor's manufacturer's instruction sheets and the home's education material for staff indicated that staff were instructed to apply identified physical devices as follows:

"'Posey' Lapbelt/Padded Lap belt Application instructions": "Adjust the tightness of the slide buckles. Check that the straps are secure and will not change position, loosen, or tighten if the patient pulls on them, or if the chair is adjusted...The belt must be snug, but not interfere with breathing. To check for proper fit, slide an open hand (flat) between the belt and the patient."

"Belt Application for Proper Positioning": "To be effective, any belt must be: positioned across the hips; not across the abdomen; not too loose to allow client to slide under belt, nor too tight to irritate bony prominences or soft tissue. (Just enough space for two fingers to fit between the belt and pelvic crest)."

"Wheelchair Safety Positioning and Transportation" power point slides: "Must be snug to position client, but not so tight to cause injury, not too loose to allow client to slide under belt. Do your fingers fit snugly between the belt and the client? Difficult to get fingers in between? - Seatbelt is too tight! Gap between your fingers and belt - Seatbelt is too loose!!"

During a tour of the home on an identified date, seven identified residents were observed to have identified physical devices in place on their mobility devices. The physical devices were applied loosely. There was a gap between the physical device and the resident of three to six inches. During an interview with an identified staff member, it was confirmed that all seven identified residents were unable to undo their physical device. The staff confirmed that they were loose and not applied according to the manufacturer's instructions since they could place more than just their hand between the physical device and the resident. They reported that they instructed front line nursing staff to adjust the physical device according to manufacturer's instructions and audited the completion of this task prior to 1400 hours.

During an interview, the DOC confirmed that physical devices applied between three and six inches between the device and the resident as noted above, were not applied according to manufacturer's instructions.

(526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2017

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 : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the following are complied with. The plan is to include, but not limited to the following:

1. Ensure that resident #006, #070 and #020 are reassessed by the RD and different approaches are considered in the revision of their nutrition plan of care to attempt to improve or prevent further decline in their nutritional status.

2. Ensure that when any resident in the home is reassessed and their nutrition plan of care has been identified as ineffective, different approaches are considered in the revision of their plan of care.

The plan is to be submitted on or before June 15, 2017, to Cathy Fediash at Cathy.Fediash@ontario.ca

Grounds / Motifs :

1. This order is based upon three factors where there has been a finding of noncompliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the noncompliance is a pattern (2), the severity of the non-compliance has minimal harm or potential for actual harm (2) and the history of non-compliance under Long-Term Care Homes Act, 2007, s.6(11) is ongoing (4) with a VPC on March

9, 2016.

The licensee failed to ensure that when a resident was reassessed and the plan of care was reviewed and revised when the care set out in the plan was not effective, that different approaches were considered in the revision of the plan of care.

A) A review of resident #006's nutrition plan of care identified they were assessed to be a high nutrition risk. The resident had an identified weight on a date in 2017 that was 7.9 kilograms (kg) below the lowest weight of their assessed goal weight range.

On an identified date in 2016, a referral was received by the dietary department for the resident for low food intake (resident ate less than 75 per cent of their food for 15 out of 21 meals over a seven day period), as directed in the home's nutrition and hydration program policies and procedures. The resident was assessed by the RD and no changes were made to their nutritional plan of care. At this time the RD put in place a new referral parameter for the resident's food intake.

On a later identified date in 2016, a referral was received by the dietary department for the resident for low food intake (resident ate less than 75 per cent of their food for 15 out of 21 meals over a seven day period), as directed in the homes nutrition and hydration program policies and procedures. An assessment was not completed by the RD. In an interview with the RD on an identified date in 2017, it was confirmed that the referral was declined because the resident did not meet the new referral parameter for food intake.

On an identified date in 2016 and 2017, a quarterly nutrition assessment was completed by the RD which indicated that the resident continued to have non-significant weight loss over the previous six month period and remained at high nutrition risk. No changes were made when the nutrition plan of care was reviewed during the resident's two quarterly nutrition assessments.

In an interview on an identified date in 2017, the RD confirmed that there were no documented changes to the nutrition plan of care over the nine month period. It was confirmed that different approaches were not considered in the revision of the plan of care when current interventions had not been effective in improving the resident's nutritional status.

B) A review of resident #070's nutrition plan of care identified they were assessed to be at high nutrition risk; had a history of poor food and fluid intake and were noted to have a nine percent (%) gradual weight loss over an identified period of six months. The resident had an identified weight on a date in 2017 that was 3 kg below the lowest weight of their assessed goal weight range.

Referrals were made to the RD for resident #070, on four identified dates in 2016, as directed in the home's nutrition and hydration program policies and procedures for low food and fluid intake as well as refusal of their identified daily supplement that was put into place prior, for poor intake.

Following the last referral, the RD put in place a new referral parameter for fluid intake for the resident and the resident's identified supplement was discontinued. At this time no new interventions were trialled to improve resident #070's food and fluid intake and no interventions were trialled in relation to the resident previous supplement refusal.

On an identified date following the new referral parameter being put into place a referral was received by the dietary department for the resident for low fluid intake as directed in the home's nutrition and hydration program policies and procedures. An assessment was not completed by the RD. In an interview with the RD on an identified date in 2017, it was confirmed that the referral was declined because the resident did not meet the new referral parameter that had been put into place.

In an interview with the RD, it was confirmed that there were no documented changes to the nutrition plan of care since the resident's admission nutrition assessment on an identified date in 2016. It was confirmed that different approaches were not considered in the revision of the plan of care when current interventions had not been effective in preventing a decline to the resident's nutritional status.

C) A review of resident #020's nutrition plan of care identified they were assessed to be at high nutrition risk and a history of poor food and fluid intake and were noted to have a nine percent gradual weight loss over six months. The resident had an identified weight on a date in 2017 that was 23.4 kg below the lowest weight of their ideal body weight range.

On an identified date in 2016, a referral was received by the dietary department for resident #020 for low food intake as directed in the home's nutrition and hydration program policies and procedures. The resident was assessed by the RD and no new interventions were trialled at that time. At this time the RD put in place a new food and fluid referral parameter that identified when resident #020 should be referred.

On two identified dates in 2016 and one identified date in 2017, a quarterly nutrition assessment was completed by the RD. It was documented that the resident continued to be at high nutrition risk with an ongoing decline in nutritional status. No new nutrition interventions were trialled at the three quarterly assessments.

An RD assessment completed on an identified date in 2016, identified resident #020 was on an identified daily supplement and indicated that a further increase would not be trialled based on their previous refusals. In an interview with registered staff #300 on an identified date in 2017, they shared the resident usually takes the supplement well, typical 100 per cent.

In an interview with the RD it was confirmed as per the documented assessments, a new nutrition intervention was last trialled for resident #020 on an identified date in late 2015. A review of resident #020's weights show that their weight had decreased 6.3 kg over an identified period of approximately 15 months. It was confirmed that different approaches were not considered in the revision of the plan of care when current interventions had not been effective in improving resident #020's nutritional status.
(583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 03, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 complete the following:

1. Ensure that the nutrition care and dietary services and hydration program policies and procedures relating to the system to monitor and evaluate the food and fluid intake of residents are followed.

2. Discontinue the lower parameters to trigger a food or fluid referral to the RD for the 54 residents identified at moderate or high nutrition risk who had a history of poor food and/or fluid intake.

3. For any resident who is assessed to require less than 1000 ml of total fluids per day and require a different fluid parameter trigger or for any residents who require a different food intake parameter trigger ensure that:

i) The RD completes an interdisciplinary assessment and assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s.26(4)
ii) Resident food and fluid requirements and paramaters to trigger a referral to the RD for low intake are in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Grounds / Motifs :

1. This order is based upon three factors where there has been a finding of noncompliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the noncompliance is widespread (3), the severity of the non-compliance has minimal harm or potential for actual harm (2) and the history of non-compliance under Ontario Regulation 79/10, r. 68(2) is ongoing (4) with a Written Notification (WN) issued on March 9, 2016 and a Compliance Order (CO) issued on July 27, 2015.

1. The licensee failed to ensure that the nutrition care and dietary services and hydration program policies and procedures, relating to the system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration were implemented.

A review of the "Dietary Referral Process for Documented Food Intake < 75% and Fluid Intake < 1000 ml per Day", dated with an identified date in 2017, identified nursing staff were to make a referral to the RD when:

i) a resident ate less than 75 per cent of their food for 15 out of 21 meals over a seven day period
ii) a resident refused to eat for more than three days
iii) a residents fluid intake was less than 1000 ml per day for five days in a row

For residents that did not require 1000 ml per day of total fluids the procedure identified that a different parameter to trigger a referral for low fluid intake would be set by the Food Service Nutrition Manager (FSNM) or the RD and communicated on the resident's flow sheet.

A review of the "RD referrals for poor food or fluid intake" record, provided by the FSNM on an identified date in 2017, identified that 54 residents were put on lower parameters to trigger a referral to the RD for low food and fluid intake than directed by the home's procedure. The 54 residents identified on the record were at moderate or high nutrition risk and had a history of poor food or fluid intake.

It was identified nursing staff were to make a referral to the RD for low food intake when:

i) a resident ate less than 50 per cent of their food for 15 out of 21 meals over a seven day period – put in place for 17 residents
ii) a resident had no food intake for three days in a row – put in place for 19 residents

It was identified nursing staff were to make a referral to the RD for low fluid intake when:

i) fluid intake was less than 800 ml per day for five days in a row – put in place for three residents
ii) fluid intake was less than 750 ml per day for five days in a row – put in place for four residents
iii) fluid intake was less than 700 ml per day for five days in a row – put in place for four residents
iv) fluid intake was less than 650 ml per day for five days in a row – put in place for three residents
v) fluid intake was less than 625 ml per day for five days in a row – put in place for one resident
vi) fluid intake was less than 600 ml per day for five days in a row – put in place

for four residents
vii) fluid intake was less than 575 ml per day for five days in a row – put in place for three residents
viii) fluid intake was less than 550 ml per day for five days in a row – put in place for two residents
ix) fluid intake was less than 500 ml per day for five days in a row – put in place for seven residents
x) fluid intake was less than 475 ml per day for five days in a row – put in place for one resident
xi) fluid intake was less than 450 ml per day for five days in a row – put in place for two residents
xii) fluid intake was less than 400 ml per day for five days in a row – put in place for two residents
xiii) fluid intake was less than 300 ml per day for five days in a row – put in place for one resident
xiv) fluid intake was 0 ml per day for a three days in a row – put in place for one resident

The "Hydration Management" (CD-05-12-1) policy provided suggested methods to use when calculating estimated fluid needs. According to the homes policy one resident out of 38 residents put on lower fluid parameter to trigger an RD referral may have required less than 1000 ml per day. The identified resident had been placed on a parameter of having zero ml per day for three days in a row before a referral would be sent to the RD.

The Administrator and the RD were interviewed about the home's system to monitor and evaluate the food and fluid intake of residents with identified risks. It was confirmed that there was no procedure or policy developed or implemented for the homes new practice of setting different parameters to trigger a low food and fluid intake for 54 residents identified. It was confirmed that the policies and procedures related to nutrition and hydration were not implemented as directed in the homes nutrition care and hydration program. (583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 03, 2017

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. 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.

Order / Ordre :

The licensee shall complete the following:

1. Ensure that resident's #047 and #070 weight changes are assessed by the RD using an interdisciplinary approach, and that action is taken and the outcome is evaluated.

2. Implement a process to ensure residents with a weight change of 5 per cent of body weight, or more in one month; a change of 7.5 per cent of body weight or more, over three months; a change of 10 per cent of body weight, or more, over 6 months; or any other weight change that compromised the resident's health status are identified.

3. Ensure all identified residents with significant weight changes are assessed using an interdisciplinary approach, and that action is taken and the outcome is evaluated.

4. Develop and implement an auditing process to ensure residents with significant weight changes are identified and assessed.

Grounds / Motifs :

1. This order is based upon three factors where there has been a finding of non-compliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the non-compliance is a pattern (2), the severity of the non-compliance has minimal harm or potential for actual harm (2) and the history of non-compliance under Ontario Regulation 79/10, r. 69 is ongoing (2) with one or more unrelated non-compliance in the last 3 years.

The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were 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.

A) A review of resident #018's clinical record indicated that on an identified date in 2017, the resident had an identified weight loss of 7.4 % over an identified period of one month; a 9.9 % weight loss over an identified period of three months and a 12.3% weight loss over an identified period of 6 months.

A review of the resident's clinical record indicated that no assessment had been completed when the resident sustained a weight change for an identified time period of more than 5 % over one month; more than 7.5 % over three months and more than 10 % over 6 months. An interview with the RD confirmed that the resident had not been assessed when they demonstrated the identified weight changes.

B) A review of resident #047's nutrition plan of care identified they were assessed to be at high nutrition risk.

On an identified date in 2016, resident #047's identified weight triggered a significant weight change of 5 per cent of body weight, or more in one month; a change of 7.5 per cent of body weight or more, over three months and a change of 10 per cent of body weight.

On an identified date in 2017, resident #047's identified weight triggered a significant weight change of 5 per cent of body weight, or more in one month; a change of 7.5 per cent of body weight in or more, over three months; a change

of 10 per cent of body weight.

A review of resident #047's progress notes identified that the resident's significant weight changes were not assessed by the RD using a multidisciplinary approach. A review of the documented nutrition assessments completed for an identified period of approximately one year identified that no actions had been taken. One change was documented on an identified date in 2016 which identified that the resident's identified supplement was decreased by 40 ml daily.

In an interview with the RD it was shared that the home did not have a monitoring process in place to identify when residents had a significant weight change. It was confirmed with the RD that the resident's significant weight changes on three identified months were not assessed using an interdisciplinary approach, and actions were not taken.

C) A review of resident #070's nutrition plan of care identified they were assessed to be at high nutrition risk and had a history of poor food and fluid intake.

A review of the clinical record indicated that over an identified period of time, resident #070's had a gradual weight loss of nine per cent over six months. On an identified date in 2017, the resident's weight fell below their ideal body weight range (IBWR) and continued to decline over the next two months.

A review of the progress notes identified that resident was last assessed by the RD on an identified date in 2017. It was noted that the resident had not been assessed when their weight fell below an IBWR and continued to decline by the RD using a multidisciplinary approach.

In an interview with the RD it was shared that the home did not have a monitoring process in place to identify when resident's had weight changes that compromised their health status. It was confirmed that resident #070's had not received a nutrition assessment in greater than four months, that their weight change was not assessed using an interdisciplinary approach and actions were not taken.
(583)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 03, 2017

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 : 005

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

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 shall prepare, submit and implement a plan to ensure that the following are complied with. The plan is to include, but not limited to the following:

1. All resident's including resident's #022, 027, 029 and 034 shall be protected from abuse by anyone.

2. The policy that promotes zero tolerance of abuse and neglect of residents is complied with.

The licensee shall also prepare, submit and implement a plan in relation to the home's Nutrition and Hydration Program to ensure that the following are complied with. The plan is to include but not limited to the following:

1. Ensure the RD is on site and in the home 30 minutes per resident per month to carry out clinical and nutrition care duties.

2. Ensure the home policies and procedures relating to the nutrition care and dietary services and hydration are implemented.

3. Develop and implement an auditing process to ensure residents with significant weight changes, low food and fluid intake and any other significant changes that comprise the resident's nutritional status are identified and assessed.

The plan is to be submitted on or before June 15, 2017, to Cathy Fediash at Cathy.Fediash@ontario.ca

Grounds / Motifs :

1. This order is based upon three factors where there has been a finding of non-compliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the non-compliance is a pattern (2), the severity of the non-compliance has minimal harm or potential for actual harm (2) and the history of non-compliance under Long-Term Care Homes Act, 2007, s.19(1) is ongoing (2) with one or more unrelated non-compliance in the last 3 years.

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

A) On an identified date in 2017, staff #138 was providing care to resident #027 when resident #027 made a comment to the staff member which frustrated the staff causing the staff member to leave the room. When the staff member returned to the room, they made a comment to the resident that was witnessed by another resident. The comment was degrading and upset the resident.

Staff #138 knew that they had been verbally abusive to the resident and immediately reported the incident to the Registered Nurse. The home responded to the incident and support was provided to the resident.

It was confirmed during an interview with the Administrator that resident #027 was not protected from abuse by anyone.

PLEASE NOTE: This non compliance was identified during a complaint inspection, log #020862-16, conducted concurrently during this RQI.

B) On an identified date in 2016, it was witnessed by staff #264 that resident #023 grabbed the hand of resident #022 and then resident #023 touched resident #022's in an identified area. Staff #264 immediately intervened and separated the two residents and reported the incident to the registered nurse.

Resident #022 was incapable of consenting to the identified actions of resident #023. During an interview with staff #264 on an identified date the staff confirmed that the incident was non-consensual. Documentation also confirmed that the resident was incapable of providing consent to the actions by resident #023.

It was confirmed that the licensee failed to ensure that resident #022 was protected from abuse by anyone.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection, log #030249-16, conducted concurrently during this RQI.

C) On an identified date in 2016, resident #029 reported to staff that resident #033 grabbed them in an identified area without their consent. Resident #033 had known responsive behaviours towards co-residents and staff.

It was confirmed during review of the resident's clinical record and during an

interview with the Administrator that resident #029 was not protected from abuse by resident #033.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection, log #014903-16, conducted concurrently during this RQI.

D) On an identified date in 2016, it was witnessed by staff that resident #033 was touching resident #034 on an identified area. Resident #033 had known responsive behaviours towards co-residents and staff.

It was confirmed during a review of the resident's clinical record that they were unable to consent. An interview with the Administrator confirmed that resident #034 was not protected from abuse by anyone.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection, log # 018391-16, conducted concurrently during this RQI.

The licensee failed to ensure that residents were not neglected by the licensee or staff.

A) The following residents were not assessed using an interdisciplinary approach, and actions were not taken and outcomes were not evaluated when they had a significant weight change or any other weight change that compromised their health status.

i) In an interview with the RD on an identified date in 2017, it was confirmed that resident #047's significant weight changes over three identified months were not assessed using an interdisciplinary approach, and actions were not taken. Resident #047 was assessed to be at high nutrition risk. During this 12 month period the resident had a 12 % weight loss and their weight fell below their IBWR.

ii) In an interview with the RD on an identified date in 2017, it was confirmed resident #070's weight change that compromised their health status, was not assessed. Resident #070 was assessed to be at high nutrition risk. On an identified date in 2017, resident #070's weight fell below their IBWR and continued to decline over the next two months, resulting in a 10% weight loss in six months.

In an interview with the RD it was shared that the home did not have a monitoring process in place to identify when residents had a significant weight change or any other weight change that compromised the resident's health status.

B) When the following resident's nutrition plans of care were reassessed and the plans of care were reviewed and revised when the care set out in the plans were not effective, different approaches were not considered in the revision of the plans of care.

i) Resident #006 was referred to the RD on identified dates in 2016, for low food intake and again seven days later for low food intake. On an identified date's in 2016 and 2017, a quarterly nutrition assessments were completed by the RD. It was documented that the resident continued to have non-significant weight loss over the previous six month period; remained underweight with an identified low BMI; had ongoing variable intake and remained at high nutrition risk.

In an interview on an identified date in 2017, with the RD, it was confirmed that there were no documented changes to the nutrition plan of care over the nine month period. It was confirmed that different approaches were not considered in the revision of the plan of care when current interventions had not been effective in improving resident #006's nutritional status.

ii) Resident #070 was referred to the RD on two identified dates, which were two days apart, in 2016, for low food intake. The resident was referred 12 days later for low fluid intake and declining supplements. The resident was referred to the RD one day later for low fluid intake. It was documented that the resident was at high nutrition risk; had a history of poor food and fluid intake and was noted to have a nine % gradual weight loss over six months in which their weight fell below their IBWR.

In an interview on an identified date in 2017, with the RD, it was confirmed that there were no documented changes to the nutrition plan of care since resident #070's identified nutrition assessment, approximately seven months prior. It was confirmed that different approaches were not considered in the revision of the plan of care when current interventions had not been effective in preventing a decline to resident #070's nutritional status.

iii) Resident #020 was referred to the RD on an identified date in 2016, for low food intake. On two identified dates in 2016 and one identified date in 2017, quarterly nutrition assessments were completed by the RD. It was documented that the resident was at high nutrition risk; severely underweight and a history of poor food and fluid intake and were noted to have a nine % gradual weight loss over six months. On an identified date in 2017, resident #020's weight was 23.4 kg below the lowest weight of their ideal body weight range.

In an interview with the RD on an identified date in 2017, it was confirmed as per the documented assessments, a new nutrition intervention was last trialled for resident #020 on an identified date in 2015. A review of the resident's clinical record showed that the resident's weight had decreased 6.3 kg over an identified period of approximately 15 months. It was confirmed that different approaches were not considered in the revision of the plan of care when current interventions had not been effective in improving resident #020's nutritional status.

C) The licensee failed to ensure that the nutrition care and dietary services and hydration program policies and procedures relating to the system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration were implemented.
A review of the "Dietary Referral Process for Documented Food Intake < 75% and Fluid Intake < 1000 ml per Day", dated January 2017, identified nursing staff were to make a referral to the RD when:

i) a resident ate less than 75 per cent of their food for 15 out of 21 meals over a seven day period
ii) a resident refused to eat for more than three days
iii) a residents fluid intake was less than 1000 ml per day for five days in a row

For residents that did not require 1000 ml per day of total fluids, the procedure identified a different parameter to trigger a referral for low fluid intake which would be set by the FSNM or the RD and communicated on the resident's flow sheet.

A review of the "RD referrals for poor food or fluid intake" record, provided by the FSNM on an identified date in 2017, identified that 54 residents were put on lower parameters to trigger a referral to the RD for low food and fluid intake than directed by the homes procedure. The 54 residents identified on the record

were at moderate or high nutrition risk and had a history of poor food or fluid intake.

In an interview with the RD on an identified date in 2017, they were asked to share why residents were put on lower parameters to trigger a low fluid or food intake referral than directed in the homes policy. It was shared that the home was having difficulty managing the number of referrals when the system was implemented. The RD shared they re-calculated the parameters to reduce the amount of referrals to an "appropriate amount of referrals". In an interview with the Administrator it was confirmed they were aware of the changes in the referral process to the RD.

D) The registered dietitian was not on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties during the time period reviewed.

The home had a bed capacity of 153 residents. The hours that the RD was required to complete monthly based on 30 minutes per resident was 76.5 hours. This was confirmed with the Administrator on an identified date in 2017.

In an interview with the RD on an identified date in 2017, it was confirmed that out of the required 76.5 hours per month required to be completed on site at the home only 51 hours were completed in one identified month, 46 hours in the following month and 50.5 hours in the identified month following. It was confirmed with the Administrator that the required 76.5 monthly RD hours to carry out clinical and nutrition care duties were not completed on site.

The lack of action taken to address residents who demonstrated weight loss; lack of different approaches considered in the revision of the resident's plan of care to improve their nutritional status related to weight loss; the lack of ensuring that the home's policies and procedures were implemented related to monitoring and evaluating resident's with identified nutrition and hydration risks and not ensuring that the registered dietitian was on site at the home for a minimum of 30 minutes per resident per month, demonstrated that residents who were at a high nutrition risk were not provided with the nutritional care required for health and well-being, showing a pattern of inaction that jeopardizes the health and well-being of one or more residents.

The plan is to be submitted on or before June 9, 2017, to Cathy Fediash at

Cathy.Fediash@ontario.ca
(508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 03, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 31st day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CATHY FEDIASH

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