Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

London Service Area Office
130 Dufferin Avenue, 4th floor
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection/ Genre d'inspection
Aug 25, 2014;	2014_243504_0011 (A1)	L-000425-14	Resident Quality Inspection

Licensee/Titulaire de permis

VIGOUR LIMITED PARTNERSHIP ON BEHALF OF VIGOUR
302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - OXFORD
263 WONHAM STREET SOUTH, INGERSOLL, ON, N5C-3P6

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

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

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

DEIRDRE BOYLE (504) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The comply by date for CO #001 on the original Public Order Report has been changed to December 8, 2014.

Issued on this 25 day of August 2014 (A1)

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

Ontario

Ministry of Health and Long-Term Care

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

DEIRDRE BOYLE (504) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): April 14, 15, 16, 17, 22 and 23, 2014.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Food Services Supervisor and Environmental Services Manager, RAI Coordinator, Programs Manager, Maintenance staff, Physiotherapist, Physiotherapy Assistant, Pharmacist, Office Manager, 2 Registered Nurses, 2 Registered Practical Nurses, 10 Personal Support Workers, 3 Dietary Aides, 1 Laundry Aide, 3 Resident family members and 40+ Residents.

During the course of the inspection, the inspector(s) reviewed clinical records, interviewed Residents, staff and family members, observed dining room service and medication administration, toured Resident care areas, observed Resident care, and reviewed policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Safe and Secure Home

Skin and Wound Care

Trust Accounts

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 84. s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. The licensee failed to develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care services, programs and goods provided to residents as evidenced by:

a) The home did not conduct a Resident and Family satisfaction survey in 2013. This was confirmed by the Executive Director and Programs Manager.

b) The home did not seek input from the Residents' Council or Family Council for the satisfaction survey for 2014. This was confirmed by the Executive Director and Programs Manager.

c) The home did not have a written description of its goals, objectives, policies, procedures and protocols or a process to identify initiatives for review for quality improvement in 2013 or 2014. This was confirmed by the Executive Director and the Programs Manager.

d) The home has not completed an evaluation of required programs or the Operating Plan which serves as the quality improvement plan. This was confirmed by the Executive Director and the Programs Manager.

e) The home has not maintained a record of improvements made to the quality of the accommodation, care, services, programs and goods provided to residents with dates. This was confirmed by the Executive Director and the Programs Manager.

f) The Executive Director and the Program Manager confirmed that the Operating Plan, quality improvement and required programs are to be discussed at monthly Quality Council meetings and that they have not had a Quality Council meeting in over one year. The home was not able to produce minutes for any Quality Council meetings. [s. 84.]

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (1) Every licensee of a long-term care home shall ensure that there is an infection prevention and control program for the home. 2007, c. 8, s. 86. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home has an infection prevention and control program as evidenced by:

The Executive Director confirmed that the home does not have an infection prevention and control program, they currently do not have an infection control lead and do not hold infection control meetings. She confirmed that she is aware of the expectation that there is an infection prevention and control program. [s. 86. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure the physiotherapy plan of care set out clear directions to staff and others who provide direct care to the resident as evidenced by:

a) Review of resident #9067's care plan of November, 2013, January, 2014 and April, 2014 stated the resident was receiving specific interventions three times per week with the Physiotherapy Assistant.

b) Interview with a Personal Support Worker, Restorative Care Aide and Physiotherapy Assistant revealed that the resident does not receive physiotherapy support.

c) Interview with the Assistant Director of Care (ADOC) confirmed that the plan of care did not provide clear direction to staff regarding physiotherapy support for resident #9067. [s. 6. (1) (c)]

2. The licensee failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident regarding continence care and bowel management, as evidenced by:

a) Interview with a Registered Nurse and a Personal Support Worker revealed that Resident #9090 uses a particular brief for incontinence and this is documented in the Kardex. The Care Plan revealed that the Resident uses a different incontinence product to the product described by the Registered Nurse and the Personal Support Worker. This was confirmed by a Registered Nurse.

b) The Care Plan revealed that the resident will use the call bell to alert staff that she has to use the bathroom. A Personal Support Worker indicated that the resident does not consistently use the call bell, rather, that staff go to the resident's room to ask her if she would like assistance with toileting. This was confirmed by a Registered Nurse.

c) Staff check the resident's brief throughout each shift to determine if it needs to be changed and this is not documented in the care plan. The Care Plan does not set out clear direction to staff regarding continence care and bowel management. This was confirmed by a Registered Nurse and by a Personal Support Worker. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out, a) the planned care for the resident; b) the goals the care is intended to achieve and c) clear directions to staff and other who provide direct care to the resident., to be implemented voluntarily.

WN #4: 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 resident #9099 who was exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated as evidenced by;

a) Review of clinical records revealed that over a four month period only two skin and wound assessments had been completed by the registered staff.

b) Interviews with two Registered Staff and the RAI-HC Co-ordinator/ Assistant Director of Care confirmed it is the expectation of the home that weekly skin and wound assessments be completed. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee failed to ensure that all non controlled drugs to be destroyed are altered or denatured to such an extent that its consumption is rendered impossible or improbable as evidenced by :

a) An interview with Medi-System Pharmacy Pharmacist revealed that non-controlled medications are not destroyed prior to being removed from the home by Daniel Services.

b) The Director of Care confirmed with inspectors #538, #213, #504 and #522 that the home does not alter the state of non-controlled medications before they are picked up by Daniel Services for incineration [s. 136. (6)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a drug is considered destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff assisting with resident meals participate in the implementation of the infection control program as evidenced by:

a) On April 14, 2014 at 1153 hrs, Inspector #522 observed a dietary staff member distributing 2 drinks per hand with their fingers touching the inside of the glasses.

b) The Inspector also observed a Personal Support Worker tear the crust off a resident's sandwich with her unwashed hands.

The Executive Director confirmed that the home's infection control policies were not followed. [s. 229. (4)]

2. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program as evidenced by :

a) Used, unlabeled personal care items including manual toothbrushes, electric toothbrushes, toothpaste, mouthwash, denture cups, hair brushes and combs were observed on the counters of 12 shared bathrooms.

b) An unlocked 2 door cupboard on East wing contained a bucket with a toilet plunger on the floor. On the floor beside it was a basket of clean supplies for resident care containing clippers, razors, socks, petroleum jelly, A535 rub, tooth brushes, straws, barrier cream, and moisturizer cream.

c) Used, unlabeled personal care items including hair brushes, combs, stick deodorant, and nail clippers as well as 2 used bars of soap were observed sitting on tables beside the tubs in the tub room.

d) A Personal Support Worker and the Assistant Director of Care confirmed that it is an expectation that personal care items in shared bathrooms are to be labeled with the resident's name. [s. 229. (4)]

3. The licensee failed to ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee as evidenced by:

a) A record review for Resident #9116 revealed that this Resident did not have a TB skin test completed within 14 days of admission or a chest x-ray completed within 90 days of admission.

b) A Registered Nurse confirmed that this Resident should have had a TB skin test completed within 14 days of admission and she had not. [s. 229. (10) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the Infection Prevention and Control Program, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home's policy put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act, as evidenced by:

A review of the Vol 3- Resident Care Medication Management - Drug Destruction Policy Number V3-930 revised April 13, 2013 revealed under section B) 'Medication Destruction and Disposal for Narcotic and Controlled' that the registered nursing staff for the home area or for a medication cart is responsible for the following;

Discarding or Wastage of Narcotic or Controlled Medications
"if there is no other nurse in the home a Personal Support Worker can witness the discard and wastage at the time the medication is removed from the container or the container, such as an ampule is opened."

The Executive Director confirmed that the home's Discarding or Wastage of Narcotic or Controlled Medications policy does not meet the requirements of O Reg. 79/10, s. 136 (3)(a) which requires that the drugs must be destroyed by a team acting together and composed of one member of the Registered Nursing staff appointed by the Director of Care and a Physician or a Pharmacist. [s. 8. (1)]

2. The licensee failed to ensure the home's Fall Prevention Program policy was complied with as evidenced by:

The home's Falls Prevention Program policy V3-630 states, "All residents will be assessed by nursing and/or physiotherapy for risk of falls on admission, quarterly, during a significant change in status and post fall."

Review of resident # 9067's clinical record revealed the resident did not have quarterly fall assessments completed.

Interview with the Assistant Director of Care (ADOC) confirmed the resident did not have quarterly falls assessments completed. The ADOC confirmed that the home's policy was not complied with as the home was not completing quarterly falls assessments on residents. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee failed to ensure that the home's Daily Food Temperature Audit policy was complied with as evidenced by:

Review of the home's Daily Food Temperatures Audit policy V10-713 states, "Food and fluid temperatures are taken for each meal prior to distribution to the residents. The temperatures indicated on the form are the minimum standard temperatures for holding temperatures in the serveries."

Review of the Daily Food Temperature Audit Log from April 15 to April 22, 2014 revealed:

a) No milk temperatures taken prior to any dinner meals;

b) On four occasions there were no juice temperatures taken prior to the lunch meal;

c) On one occasion there was no dessert temperature taken prior the lunch meal;

d) On four occasions prior to the dinner meal and on one occasion prior to the lunch meal there was no soup temperature taken;

e) When the inspector reviewed the audit log at 1000 on April 22, 2014 temperatures had already been taken and documented for the dessert and milk served at the lunch meal.

Interview with Dietary Aide (DA) confirmed that dessert and milk temperatures were taken earlier in the morning. DA confirmed that the temps are taken when the items are prepared not when they are distributed to the residents.

Interview with the Food Services Manager confirmed the expectation that all food and fluid temperatures are taken for each meal prior to distribution to residents. [s. 8. (1) (b)]

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to report the alleged verbal abuse of a resident by an employee to the Director as evidenced by:

a) Interview with resident # 9112 revealed that she reported being verbally abused by an employee to the home's management.

b) Review of the home's investigation of the report of alleged verbal abuse revealed that the allegation of verbal abuse was confirmed.

c) Review of the home's Mandatory Reports history revealed that the abuse of the resident had not been reported to the Director.

d) This was confirmed by the Executive Director. [s. 24. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances are labelled properly and kept inaccessible to residents at all times as evidenced by:

a) A 2 door unlocked cupboard containing linens, incontinence supplies as well as 2 spray bottles was observed. One of the spray bottles was labeled 'citrus air freshener' and one was not labeled and contained an unknown liquid.

b) A Registered Nurse confirmed that the spray bottles including the unlabeled bottle were a safety risk and should not have been kept in an unlocked cupboard accessible to residents. She took the bottles and locked the cupboard. [s. 91.]

Issued on this 25 day of August 2014 (A1)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : DEIRDRE BOYLE (504) - (A1)

Inspection No. / No de l'inspection : 2014_243504_0011 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : L-000425-14 (A1)

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

Report Date(s) / Date(s) du Rapport : Aug 25, 2014;(A1)

Licensee / Titulaire de permis :
VIGOUR LIMITED PARTNERSHIP ON BEHALF OF VIGOUR
302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8

LTC Home / Foyer de SLD :
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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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : SUZANNE MEZENBERG

To VIGOUR LIMITED PARTNERSHIP ON BEHALF OF VIGOUR, 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 84. s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Order / Ordre :

(A1)
The licensee shall prepare, submit and implement a plan to ensure steps are taken to fully implement the quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to the residents of the long-term care home.

The written compliance plan shall include at a minimum the following:

1. A written description of the home s quality improvement and utilization review system that includes goals, objectives, policies, procedures, protocols and a current plan that relates to current and pertinent quality initiatives in the home.

2. A process for reporting complaints, that is reviewed and analyzed at least quarterly for trends, to determine what improvements are required in the home.

3. A review of the policies and procedures for all organized programs in the home to ensure that they are up to date and reflect current Ministry of Health and Long Term Care legislation and regulations.

4. How concerns and recommendations from the Residents Council will be incorporated into the home s Quality Improvement System.

5. How other departments programs will monitor, analyze, evaluate and improve quality in their respective areas. Include time lines.

6. Maintain a record of improvements and program evaluations. Include dates.

7. Maintain a record of minutes of each Quality Council meeting.

The plan shall be submitted to Deirdre Boyle, LTC Homes Inspector, either by mail or e-mail to: 130 Dufferin Avenue, 4th Floor, London, ON N6A 5R2 or deirdre.boyle@ontario.ca by June 30, 2014.

Grounds / Motifs :

1. The licensee failed to develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care services, programs and goods provided to residents as evidenced by:
a) The home did not conduct a Resident and Family satisfaction survey in 2013. This was confirmed by the Executive Director and Programs Manager.

b) The home did not seek input from the Residents' Council or Family Council for the satisfaction survey for 2014. This was confirmed by the Executive Director and Programs Manager.

c) The home did not have a written description of its goals, objectives, policies, procedures and protocols or a process to identify initiatives for review for quality improvement in 2013 or 2014. This was confirmed by the Executive Director and the Programs Manager.

d) The home has not completed an evaluation of required programs or the operating plan which serves as the quality improvement plan. This was confirmed by the Executive Director and the Programs Manager.

e) The home has not maintained a record of improvements made to the quality of the accommodation, care, services, programs and goods provided to residents with dates. This was confirmed by the Executive Director and the Programs Manager.

f) The Executive Director and the Programs Manager confirmed that the operating plan, quality improvement and required programs are to be discussed at monthly Quality Council meetings and that they have not had a Quality Council meeting in over one year and were not able to produce minutes for any Quality Council meeting. (213)

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

Dec 08, 2014(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 86. (1) Every licensee of a long-term care home shall ensure that there is an infection prevention and control program for the home. 2007, c. 8, s. 86. (1).

Order / Ordre :

Ontario

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

The licensee must prepare, submit and implement a plan for achieving compliance with the LTCH Act 2007, c.8, s. 86. (1) to ensure that there is an infection prevention and control program for the home.

1. The plan must ensure that the following are developed and implemented in the home:

a) daily monitoring to detect the presence of infections in residents of the long-term care home,

b) measures to prevent the transmission of infections,

c) appointment of an Infection Control Lead and,

d) comply with any standards and requirements, including required outcomes, provided for in the regulations.

The plan shall be submitted to Deirdre Boyle, LTC Homes Inspector, either by mail or e-mail
to: 130 Dufferin Avenue, 4th Floor, London, ON N6A 5R2 or deirdre.boyle@ontario.ca by
June 30, 2014.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

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Grounds / Motifs :

1. The licensee failed to ensure that the home has an infection prevention and control program as evidenced by:

a) The Executive Director confirmed that the home does not have an infection prevention and control program.

b) The home currently does not have an infection control lead and does not hold infection control meetings.

c) The Executive Director confirmed that she is aware of the expectation that there is to be an infection prevention and control program.
(213)

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

Jul 15, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 25 day of August 2014 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DEIRDRE BOYLE - (A1)

Service Area Office /
Bureau régional de services : London