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 15, 2017	2017_363659_0002	002150-17	Complaint

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite #200 MARKHAM ON L3R 0E8

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

Secord Trails Care Community
263 WONHAM STREET SOUTH INGERSOLL ON N5C 3P6

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

JANETM EVANS (659), HELENE DESABRAIS (615)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 2 and 3, 2017.

The following intakes were completed:
002150-17 - IL-49028-LO Complaint related to resident fall.
002245 - 2628-000002-17 Critical Incident related to resident fall.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Associate Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers,Power of Attorney, and the Complainant.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

a) A resident's health record showed the resident was admitted on two separate dates however, no Fall Risk Assessment was completed and no initial Lifts and Transfer assessment was completed on either admission as per the home's policy.

The licensee's policies related to Falls Prevention and Resident Transfer & Lift Procedures showed that a fall risk assessment and safest lift/transfer assessment were to be completed within 24 hours of admission to the home. The Falls Prevention policy included that the fall risk assessment was also to be completed upon readmission to the home.

In an interview the Director of Care, a Registered Nurse and Registered Practical Nurses acknowledged that a fall risk assessment and the initial transfer assessment were not completed for the resident on admission and that it was the home's expectation that they would be completed as per their policy.

b) A review of the clinical record showed a resident was admitted to the home in 2017.

A review of the clinical record for the resident showed that there had not been a detailed fall risk assessment completed in the electronic documentation system nor was an initial safe transfer and lift assessment completed in the electronic documentation system or in the hard copy of the resident's chart.

A review of the progress notes for the resident showed the resident fell sustaining injuries. They were transferred and admitted to hospital where they deceased.

The licensee's policies related to Falls Prevention and Resident Transfer & Lift Procedures showed that a fall risk assessment and initial safest lift/transfer assessment were to be completed within 24 hours of admission to the home.

During interviews with the Director Of Care, Assistant Director of Care and Executive Director, they acknowledged that neither a fall risk assessment or an initial safe transfer and lift assessment were completed for the resident upon their admission and that the

expectation for the home was that these assessments should be completed within 24 hours of a resident's admission.

The licensee failed to comply with their policy related to falls prevention and resident transfer and lift procedures.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

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

Findings/Faits saillants :

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

A resident's health record showed the resident was admitted to a bed in the home on two separate dates however, no Fall Risk Assessment was completed on either admission.

A review of the resident's care plan showed risk of falls was included as well as interventions for fall prevention.

During an interview with the Director of Care, a Registered Nurse and Registered Practical Nurses, they acknowledged that the resident had not been assessed for risk for falls on their admission and that the care plan was not based on an interdisciplinary

assessment with respect to the resident's risk of falls. [s. 26. (3) 10.]

2. The licensee has failed to ensure that a resident's plan of care was based on an interdisciplinary assessment of safety risks.

A review of the assessments showed the Initial Assessment indicated that a resident used a walker for stability. The Activity of Daily Living (ADL) needs from this assessment indicated that the resident required one person physical assistance for walking/locomotion and transferring. In addition it was documented that the resident was at risk for falls.

The Minimum Data Set (MDS) assessment included the level of ADL assistance the resident required was extensive assistance from one staff for toilet use, transfers, walking and bed mobility.

A progress note documented the resident fell, sustaining an injury which required them to be transferred and admitted to hospital where they deceased.

A review of electronic record and the hard copy clinical record for the resident did not provide documented evidence that a fall risk assessment or initial safe transfer and lift assessment were completed by the licensee.

The resident's care plan did not include evidence of focus, goals or interventions specific to fall prevention.

The licensee's policies related to Falls Prevention and Resident Transfer & Lift Procedures showed that a fall risk assessment and initial safest lift/transfer assessment were to be completed within 24 hours of admission to the home. The Falls Prevention policy included that the fall risk assessment was also to be completed upon readmission to the home.

In interviews, the Director of Care acknowledged the Falls Risk Assessment had not been completed and that there were no interventions in place for the resident related to falls. Executive Director acknowledged the Transfers and Lifts assessment had not been completed nor had a Fall Risk Assessment been completed.

The licensee failed to ensure that the resident's plan of care was based on an interdisciplinary assessment of safety risks.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Review of the Minimum Data Set (MDS) assessment, the homes initial assessment and the resident's care plan showed varied documentation related to the level of assistance the resident required ranging from the resident being independent to requiring extensive from one staff for Activity of Daily Living (ADL's).

The resident's care plan did not identify the resident as at risk for falls.

Point of Care (POC) documentation for the resident for a twelve day period included the resident was provided varied assistance from staff and the documentation indicated the resident was independent to totally dependent on staff for assistance with ADL's.

During interviews a Personal Support Worker(PSW) and the Assistant Director of Care (ADOC) said that the resident required supervision or assistance with ambulating and Activities of Daily Living (ADL's). In other interviews, PSW's, a Registered Practical Nurse and a Registered Nurse stated the resident was independent for ambulation and transfers. The Director of Care stated the resident was independent and acknowledged the care plan documented the resident required assistance with ADL's.

The licensee failed to ensure that the written plan of care for the resident set out clear directions to staff and others who provided direct care to the resident.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 with ensuring that the plan of care for all residents set out clear directions to staff and others who provide direct care to residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a continence assessment was completed for a resident which included identification of causal factors, type of incontinence and potential to restore function with specific interventions using a clinically appropriate assessment instrument which was specifically designed for assessment of incontinence.

A resident was admitted to the home in 2017.

The Minimum Data Set (MDS) assessment documented the resident as usually continent for bowel and bladder, that they were on a toileting program and used continence products as needed. A Initial Assessment v. 3 documented the resident as being continent for bowel and bladder and that the resident wore a continence product for possible soiling.

A three day Product/Bladder Diary initiated upon the resident's admission showed the resident had two episodes of incontinence.

A review of Point of Care (POC) continence documentation for eleven days from the resident's admission documented a resident had five episodes of incontinence.

During interviews Personal Support Workers (PSW) and a Registered Practical Nurse (RPN) stated that the resident was continent and was known to self toilet or did not require assistance to toilet. Another PSW stated that the resident was confused on occasion and could not find the toilet or would self toilet and remove their continence product and leave it in the toilet.

In interviews the Director of Care and Assistant Director of Care acknowledged a continence assessment had not been completed for a resident.

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that for each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that there was a written description of the program that includes its:goals and objectives, relevant policies, procedures, protocols, methods to reduce risk, methods to monitor outcomes, and protocols for referral of resident to specialized resources where required.

On February 3, 2017 the licensee was unable to produce a falls prevention and management program which included goals and objectives and protocols for referral of resident to specialized resources where required.

During an interview the Executive Director acknowledged that the licensee did not have a Falls Prevention and Management program which included goals, objectives and protocols for referral of a resident to specialized resources where required.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that direct care staff were provided with training in Falls Prevention Management.

A review of training documentation for 2016 related to falls management showed that approximately 14/44 staff who provide direct care had not completed the training related to Falls Prevention Management. It also appeared that 4/26 Registered staff had not completed the training.

The Executive Director acknowledged that the training records showed the 2016 training had not been completed for all staff and the expectation was that staff received the training annually [s. 221. (1) 1.]

2. The licensee has failed to ensure that annual training related to continence care and bowel management was provided to all staff who provide direct care to residents.

A review of the 2016 training documentation showed that 14/44 staff who provide direct care had not completed the annual training for direct care staff related to Continence Management.

The Executive Director acknowledged that the 2016 training records showed the training for continence care and bowel management had not been completed for all direct care staff and the expectation was that staff received the training annually.

Issued on this 13th day of July, 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) :	JANETM EVANS (659), HELENE DESABRAIS (615)
Inspection No. / No de l'inspection :	2017_363659_0002
Log No. / Registre no:	002150-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 15, 2017
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Secord Trails Care Community 263 WONHAM STREET SOUTH, INGERSOLL, ON, N5C-3P6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Ellen Coffey

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., 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. 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee will ensure that the home's Fall Prevention policy and Transfer and Lifts Procedures policy are complied with. Specifically the licensee will ensure that every resident will have a fall risk assessment and a lifts and transfer assessment completed within 24 hours of admission to the home.

Grounds / Motifs :

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

a) Are of the clinical record showed a resident was admitted to the home in 2017.

A review of the clinical record for the resident showed that there had not been a detailed fall risk assessment completed in the electronic documentation system not was an initial safe transfer and lift assessment completed in the electronic documentation system or in the hard copy of he resident's chart.

A review of the progress notes for the resident showed the resident fell, sustaining injuries. They were transferred and admitted to hospital where they deceased.

The licensee's policies related to Falls Prevention and Resident Transfer & Lift Procedures showed that a fall risk assessment and safest lift/transfer

assessment were to be completed within 24 hours of admission to the home.

During interviews the Director Of Care, Assistant Director of Care and Executive Director acknowledged that neither a Fall Risk Assessment or a Transfer and Lift Assessment was completed for the resident upon their admission and that the expectation for the home was that both of these assessments should be completed within 24 hours of a resident's admission.

b) A review of a resident's health record showed that there was no documented evidence to support that a Fall Risk Assessment and an Initial Lifts and Transfer assessment were completed as per the home's policy.

The licensee's policies related to Falls Prevention and Resident Transfer & Lift Procedures showed that a fall risk assessment and safest lift/transfer assessment were to be completed within 24 hours of admission to the home. The Fall Prevention policy included that the fall risk assessment was also to be completed upon readmission to the home.

In an interview the Director of Care, a Registered Nurse and Registered Practical Nurses acknowledged that a fall risk assessment and the initial transfer assessment were not completed for the resident on admission and that it was the home's expectation that they would be completed as per their policy.

The licensee failed to comply with their policy related to falls prevention and resident transfer and lift procedures.

The severity of this issue was level two with a potential risk for harm to residents. The scope was a pattern. The home had a history of non-compliance with this subsection of the regulation. It was issued as a written notice on April 23, 2014 and a voluntary plan of correction on March 30, 2015 and June 2, 2015.
(659)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 15, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The licensee will ensure that the plan of care for resident #005 and all residents is based on an interdisciplinary assessment of residents risk of falls and of safety risks.

Grounds / Motifs :

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

A resident's health record showed the resident was admitted on two separate dates, however, no Fall Risk Assessment was completed ad no initial Lifts and Transfer Assessment was completed on either admission as per the home's policy.

A review of the resident's care plan showed fall risk and interventions were included in the plan of care.

During an interview with Director of Care, Registered Nurse and Registered Practical Nurses, they acknowledged that the resident had not been assessed for risk for falls on their admission and that the care plan was not based on an interdisciplinary assessment with respect to the resident's risk of falls. (615)

2. The licensee has failed to ensure that resident #001's plan of care was based on an interdisciplinary assessment of safety risks.

A review of the assessments showed the Initial Assessment for a specific resident indicated they used a walker for stability for an unsteady gait. The Activity of Daily Living (ADL) needs from this assessment indicated that the resident required one person physical assistance for walking/locomotion and transferring and the resident was at risk for falls.

The Minimum Data Set (MDS) assessment included the level of ADL assistance the resident required was extensive assistance from one staff for toilet use, transfers and walking and bed mobility.

A progress note documented the resident fell, sustaining an injury which required them to be transferred and admitted to hospital where thy deceased.

The resident's care plan did not include evidence of focus, goals or interventions specific to fall prevention.

The licensee's policies for Falls Prevention and Resident Transfer & Lift Procedures documented that a fall risk assessment and initial assessment of the safest lift/transfer were to be completed with each resident within 24 hours of admission.

In interviews, the Director of Care (DOC) acknowledged the Falls Risk Assessment had not been completed and that there were no interventions in place for the resident related to falls. The Executive Director (ED) acknowledged the Transfers and Lifts assessment had not been completed nor had a Fall Risk Assessment been completed.

The licensee failed to ensure that resident #001's plan of care was based on an interdisciplinary assessment of safety risks.

The severity of the issue was potential for risk or harm to residents. The scope of the issue was a pattern. The home did have a history of related non compliance and a Written Notice was issued September 2, 2016. (659)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 15, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee will ensure that the plan of care for all residents will set out clear directions to staff and others who provide direct care to residents.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Review of the Minimum Data Set (MDS) assessment, the home's initial assessment and the resident's care plan showed varied documentation related to the level of assistance the resident required ranging from the resident being independent to needing extensive assistance from one staff for Activity of Daily Living (ADL's).

The resident's care plan did not identify the resident as at risk for falls.

Point of Care (POC) documentation for the resident for a twelve day period included varied documentation related to the level of care provided, from the resident being independent to the resident being totally dependent on staff for assistance with ADL's.

During interviews a Personal Support Worker(PSW) and the Assistant Director of Care (ADOC) said that the resident required supervision or assistance with ambulating and Activities of Daily Living (ADL's). In other interviews, PSW's #115, Registered Practical Nurse, and Registered Nurse stated the resident was independent for ambulation and transfers. The Director of Care stated the resident was independent and acknowledged the care plan documented the resident required assistance with ADL's.

The scope of this issue is isolated to one resident. The severity of this issue is actual harm. There is an ongoing history of non compliance with this sub-section of the regulation. It was issued as a voluntary plan of correction on April 14, 2014; March 30, 2015; and April 12, 2016.
(659)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 15, 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 15th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JanetM Evans

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