Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 18, 2015	2015_343585_0015	H-002833-15	Resident Quality Inspection

Licensee/Titulaire de permis

PARK LANE TERRACE LIMITED
284 CENTRAL AVENUE LONDON ON N6B 2C8

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

PARK LANE TERRACE
295 GRAND RIVER STREET NORTH PARIS ON N3L 2N9

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

LEAH CURLE (585), CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581)

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): July 9, 10, 13, 14, 15, 16, 17, 20, 21, 22, 2015.

One complaint inspection (log # H-002276-15), and two Critical Incident System inspections (log # H-001578-14 and H-002688-15), were conducted concurrent to the Resident Quality Inspection (RQI).

During the course of the inspection, the inspector(s) spoke with residents, families, the Administrator, Director of Care (DOC), Education Coordinator, Programs Director, Food Services Manager (FSM), Registered Dietitian (RD), Nursing Unit Managers (NUM), Resident Assessment Instrument- Minimum Data Set (RAI-MDS) Coordinator, Rehabilitation Coordinator, Dietary Aides, a Cook, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeeping staff, the Environment Services Manager (ESM), and the Office Manager.

During the course of the inspection, the inspector(s) toured the home and observed the provision of care and services, reviewed relevant clinical health records, policies and procedures, staffing schedules and complaint logs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **19 WN(s)**
- **10 VPC(s)**
- **4 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. 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,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident’s type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were provided with a range of continence care products that,
(i) were based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promoted resident comfort, ease of use, dignity and good skin integrity,
(iv) promoted continued independence wherever possible, and
(v) were appropriate for the time of day, and for the individual resident’s type of incontinence.

During the course of the inspection, it was identified that the home did not include a pull up type product in the range of continence care products provided to residents.

A) The plan of care for resident #08 identified that the resident was frequently incontinent of bladder related to mixed functional incontinence and required supervision to limited assistance, but also toileted themself at times. In June 2015, the resident was noted as having cognitive difficulty using the home's continent care products and pull ups were trialed "to maintain toileting and ease of product", as confirmed with registered staff. Interview with the resident's Power of Attorney (POA) confirmed that they were instructed that the home did not provide a pull up type product; therefore, the family was paying for a pull up product to try and maintain the resident's independence with toileting. Interview with the Personal Support Worker (PSW) staff confirmed that the resident was unable to use the home's continent pads and would be unable to apply a brief; therefore, the home did not provide a continent care product that promoted the resident's comfort, ease of use, and independence.

B) The plan of care for resident #45 identified that they were frequently incontinent of bladder related to functional incontinence and was able to self toilet successfully with the use of a pull up type product. Interview with direct care staff confirmed that the resident was not cognitively able to use the continent pads or briefs provided by home. Interview with the family confirmed that they were instructed that the home did not provide a pull up type product, therefore, they had been paying for a pull up type product to try and maintain the resident's independence with toileting. The home's range of continence products did not include one that promoted resident's #45 comfort, ease of use, and independence with toileting.

C) The plan of care for resident #46 identified that they were occasionally incontinent of bladder related to urge and used a pull up type product to "aide in toileting self". Interview with direct care staff confirmed the resident used pull ups supplied by family, which allowed the resident to toilet themself independently, as staff did not have to assist with product placement. Interview with the family confirmed that the resident was comfortable with and able to use a pull up type product and since the home did not provide a pull up, was paying for the product. The home's range of continence products did not include one that promoted resident's #46 comfort, ease of use, and independence with toileting.

D) Interviews with three TENA representatives and the Director of Care (DOC) confirmed that home's range of continent care products did not include a pull up type product; therefore, resident and families requiring or requesting a pull up type product were given the option to use the home's continent pad insert, brief, or pay for a pull up type product on their own. [s. 51. (2) (h)]

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. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) On an unspecified date in July 2015, one three quarter bed rail was observed raised on resident #08's bed. A review of the written plan of care did not indicate they required the use of one three quarter bed rail. PSWs and registered staff stated that the resident had one three quarter bed rail raised when in bed and was used for turning and positioning. A review of the resident's plan of care did not include an assessment of the bed rails being used and this was confirmed by the registered staff.

B) On two unspecified dates in July 2015, resident #80 was observed in bed with two three quarter bed rails raised. Review of the written plan of care indicated the resident required the use of two three quarter bed rails raised when in bed for positioning. PSWs and registered staff stated they used the bed rails for turning and positioning. A review of the resident's plan of care did not include an assessment of the bed rails being used and this was confirmed by the registered staff. [s. 15. (1) (a)]

2. The licensee failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The home did not take steps to mitigate the risk of entrapment for failed zones for the following residents:

i) Resident #08's plan of care identified that they used a three quarter rail daily to assist with turning and positioning while in bed. Review of the home's Bed Entrapment Audit, dated October 2014, identified that the bed system for the resident failed entrapment zones three and four, and no accessory observed to be in place to mitigate the identified entrapment zones.

ii) Resident #10's plan of care identified that they used two three quarter rails daily to assist with safety and positioning while in bed. Review of the home's Bed Entrapment Audit, dated October 2014, identified that the bed system for the resident failed entrapment zones three and four, and no accessory observed to be in place to mitigate the identified entrapment zones.

iii) Resident #80's plan of care identified that they used two three quarter rails daily when in bed for positioning and mobility when in bed. Review of the home's Bed Entrapment Audit dated October 2014, identified that the resident used an air mattress and the bed system for the resident failed entrapment zones two, three and four. No accessory observed to be in place to mitigate the identified entrapment zones.

Interview with the Administrator confirmed that the bed rails for resident #08, #10 and #80 were tightened; however, the bed systems had not been re-tested for failed zones. Steps had not been taken to prevent entrapment related to failed zones two to four for resident #08, #10 and #80's bed systems. [s. 15. (1) (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. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee filed to ensure that drugs were stored in an area or a medication cart that was secured and locked.

A) On July 9, 2015, at 1215 hours, a medication cart was found unlocked outside of dining room in Heritage Green. The Registered Practical Nurse (RPN) was in the dining room with the residents. The Long-Term Care Homes (LTCH) Inspector was able to open and close medication cart drawers without the nurse being aware. Interview with the nurse confirmed the medication cart should be locked when unattended. (528)

B) On July 10, 2015, during breakfast meal service, a medication cart was found unlocked and unattended in the hallway outside of the Heritage Green dining room. The registered staff was administering medications in the dining room. The LTCH Inspector was able to open and close the drawers without registered staff being aware. Interview with registered staff confirmed that the cart was left open when it was unattended and immediately locked the cart. (528)

C) On July 10, 2015, at 0950 hours, the nursing station and medication room on Sunrise Court was observed open. The medication cart in medication room was also unlocked. Registered staff was administering medications in a resident's room and the second registered staff was in the staff room on the computer. Four cognitively impaired residents were sitting outside of nurses station. The LTCH Inspector was able to enter the medication room and open medication cupboards and medication cart drawers

without the registered staff being aware. Interview with both registered staff revealed that they were unaware the medication room and cart were unlocked and the medication room was immediately locked. (528)

D) On July 15, 2015, during lunch service, registered staff were administering medications. The medication cart was unattended and unlocked in the hallway outside of the dining room, two residents were making their way in and out of the dining room. The LTCH Inspector was able to open and close the medication cart drawers without registered staff being aware. When registered staff exited the dining room, they confirmed the cart was left unattended and unlocked and the cart was locked immediately. (528)

E) On July 15, 2015, over lunch meal service in the Grand River dining room, a medication cart was observed unlocked and unattended while an RPN was distributing medication. The LTCH Inspector was able to open and close drawers on the cart, with the registered staff unaware. The RPN confirmed the medication cart was unlocked. (585)

F) On July 20, 2015, at 0840 hours, the medication cart in the dining room on Grand River Court was unlocked and unattended. Eight residents were finishing breakfast and registered staff was not in the dining room. The cart was left unlocked for approximately five minutes. Interview with the RPN confirmed that the medication cart was left unattended and unlocked, while they were at the nursing station. [s. 129. (1) (a) (ii)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

In November 2014, resident #80 sustained a fracture while being transferred. Review of the written plan of care and the Safety in Ambulation, Lifting and Transferring (S.A.L.T.) assessment indicated they were to be transferred with one or two person assistance with a transfer belt. Interview with the PSW who assisted the resident with the transfer stated they did not use a transfer belt. Registered staff confirmed that the staff did not use safe transferring and positioning devices or techniques when assisting resident #80. [s. 36.]

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. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

In July 2015, resident #44 was noted to have a seat belt. The resident was able to release the belt when asked; however, did not have the strength to reapply it. Interview with the rehabilitation therapist confirmed the resident used the belt daily to help with positioning. Review of the plan of care did not identify that the belt was used daily by the resident. Interview with registered staff confirmed that the plan of care did not reflect the planned care for the resident, related to use of the belt. [s. 6. (1) (a)]

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

A) On an unspecified date in July 2015, resident #60 was served a diabetic dessert. The dietary kardex in the dining room was reviewed and did not indicate the resident followed a diabetic diet. A dietary aide and PSW reported the resident followed a diabetic diet. The Food Service Manager confirmed the resident's plan of care stated they were to follow a diabetic diet, and the dietary kardex did not set out clear direction to staff and others who provided direct care to the resident. (585)

B) Resident #09's written plan of care indicated that they used a pull-up product for management of incontinence. The resident's room was observed and revealed signage noting the resident used briefs at all times, as well as a supply of briefs. Multiple PSWs reported that the resident had recently changed from using a pull up to a brief. Registered staff confirmed the written plan of care did not provide clear direction to staff reflective of the resident's care needs. [s. 6. (1) (c)]

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

A) In July 2015, resident #07 was observed wearing eye glasses. Review of the written plan of care indicated the resident wore eye glasses. The registered staff and a PSW stated that the resident wore their eye glasses when up in wheelchair. Documentation on the PSW flow sheets during the Minimum Data Set (MDS) seven day look back period in May 2015, indicated that the resident's eye glasses were cleaned daily. Review of the MDS assessment in May and February 2015 indicated that the resident did not wear glasses. The Resident Assessment Instrument (RAI) Coordinator confirmed the resident wore glasses and that the assessments were inconsistent and did not complement each other. (581)

B) Resident #08 demonstrated responsive behaviours. A review of the MDS assessment completed September 2014, identified they demonstrated two behavioural symptoms. The Resident Assessment Protocol (RAP) completed following this review stated the resident could demonstrate a third behaviour. Review of the PSW flow sheets during the seven day look back period did not indicate the resident demonstrated the third behavioural symptom.

Review of the MDS assessment completed in December 2014, identified the resident demonstrated three behavioral symptoms. This assessment also noted that there was no change in behavioral symptoms in the last 90 days.

Interview with RAI Coordinator confirmed the MDS assessment and RAP from September 2014, was not consistent with, nor complemented each other, as the resident did not demonstrate the third behaviour during that assessment period. The MDS assessment completed in December 2014 was also different from the previous assessment, when it noted there was no change in behavioral symptoms. This was confirmed by the RAI Coordinator. [s. 6. (4) (a)]

4. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) Resident #03, who was at high nutritional risk, had a plan of care to receive a diabetic reducing diet, as well as a therapeutic nutrition intervention at lunch. On an unspecified date in July 2015, the resident was observed receiving a regular dessert, and was not provided a diabetic dessert or their therapeutic nutrition intervention. The dietary aide confirmed they did not offer or provide the interventions as indicated on the plan of care. The Registered Dietitian confirmed the resident followed a diabetic reducing diet and was to receive the therapeutic pudding. (585)

B) In June 2015, staff escorted resident #42. During the transport, the resident sustained an injury.

The plan of care identified that staff were to take extra care when transferring and ensure safety around sharp objects. Interview with the PSW confirmed that they were unaware of the resident's positioning prior to the transfer; however, noted that there was no injury prior to escorting the resident.

The PSW did not take extra care to ensure resident #42 was safely positioned prior to transporting as outlined in the plan of care. (528) [s. 6. (7)]

5. The licensee failed to ensure that when a resident's care needs changed, the plan of care was reviewed and revised.

A) In February and March 2015, occupational therapy identified that resident #03

required a personal assistance services device (PASD) to maintain posture and prevent skin breakdown. In July 2015, observations and interviews with direct care staff confirmed that the resident continued to use the PASD daily. Review of the written plan of care in did not identify that the resident required the PASD. Interview with the registered staff confirmed that the written plan of care was not updated to include that the resident used the PASD daily to assist with positioning and prevention of skin breakdown. (528)

B) Review of the plan of care for resident #08 indicated they wore day liners. PSWs stated in interviews that they wore pull ups and no longer wore day liners. Registered staff confirmed that the resident wore pull ups and the written plan of care was not revised when the resident's care needs changed. (581)

C) In June 2015, registered staff assessed resident #42 to require additional interventions for positioning, and a PASD was recommended and discussed with the POA. The following day, the PASD was implemented to aid in positioning and prevent injury. Review of the written plan of care and kardex in July 2015, did not include the PASD. Interview with registered staff confirmed that the PASD was being trialed for positioning and effective, but the written plan of care was not updated to include the device. (528)

D) Review of the written plan of care for resident #80 indicated they had a cast and it was to be monitored every shift. Review of the progress notes indicated that the cast was removed in early 2015. Interviews with registered staff stated the resident no longer had a cast and confirmed that the care plan was not revised when the resident's care needs changed and the care set out in the plan was no longer necessary. (581)

E) MDS and RAP assessments from May and March 2015 identified that resident #08 demonstrated responsive behaviours. Interviews with registered staff and PSWs stated the resident demonstrated responsive behaviours most days and staff would re-approach when responsive. Review of the written plan of care did not indicate the resident exhibited responsive behaviours. Registered staff confirmed the written plan of care was not reviewed and revised to include this behaviour and intervention. (581) [s. 6. (10) (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 and ensuring that there is a written plan of care for each resident that sets out the planned care for the resident and clear directions to staff and others who provide direct care to the resident; staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; the care set out in the plan of care is provided to the resident as specified in the plans; and, that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #6: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The home's policy, "Point Click Care (PCC) Assessments", dated May 2014, stated a TENA Incontinence Management Assessment was to be completed to identify the correct incontinence management system for the resident on admission, change in condition or discontinuing the program.

i) Resident #08 was admitted to the home in March 2014. Review of the clinical records on admission revealed that a TENA Incontinence Management Assessment was not completed as required by home's policy. In June 2015, the resident's continence care needs changed and they required a change in product. Review of clinical records revealed that a TENA Incontinence Management Assessment was not completed as required, and this was confirmed by registered staff. (581)

ii) On admission in December 2014, a TENA Incontinence Management Assessment was completed for resident #09, which identified them as occasionally incontinent of bladder. In July 2015, the resident's continence care needs changed and they required a change in product, and the TENA Incontinence Management Assessment was not completed as required by the home's policy. This was confirmed by registered staff. (585)

iii) On admission in June 2015, resident #47 was identified as being frequently incontinent of bladder and required the use of a continence product. Review of the plan of care did not include a TENA Incontinence Management Assessment, to identify the correct incontinence management system for the resident, as required by home's policy. Interview with registered staff confirmed a TENA incontinence Management assessment was not completed on admission for resident #47. (528)

B) The home's policy, 'Incident Reports' dated March 2011, directed staff to complete the appropriate risk management form for any type of incident which occurred in the home that involved a resident(s) (i.e. aggressive incident, falls, bruising, skin tears).

i) In June 2015, resident #42 sustained a skin tear over two centimeters in size. Review of the plan of care identified that the wound was immediately treated and staff continued to monitor the site; however, did not include an incident report. Review of the policy indicated that skin tears of over two centimeters were to be reported. Interview with registered staff and the Administrator of the home confirmed an incident report was not completed, as per the home's policy. (528)

ii) In November 2015, resident #080 sustained a fracture while being transferred. Review of the plan of care did not include an incident report completed in the risk management form in PCC. Interview with registered staff who assessed the resident at the time of the incident confirmed that an incident report was not completed. (581)

C) The home's policy, "PCC Assessments", dated May 2014, stated the Head to Toe Assessment was to be completed when a resident returned from hospital, quarterly and leave of absence over 24 hours. The Falls Risk Assessment was to be completed on admission, readmission from hospital, post fall with or without injury and change in condition.

i) Resident #80 was in hospital for greater than 24 hours, and was readmitted in November 2014. Review of the plan of care indicated that the Head to Toe Assessment was not completed for seven days and the Falls Risk Assessment was not completed until four days post readmission from hospital. Falls Risk Assessments were completed in March and November 2014; not completed quarterly as required, according to their policy. The DOC confirmed that the reassessments were not completed in a timely manner and the Falls Risk Assessment was not completed quarterly according to the home's policy. (581)

D) The home's dietary nutrition and hydration policy, "Monitoring Residents Weight and Height, Section C.1", effective July 2013, stated:
a) Weight of all residents must be taken within 24 hours of admission;
b) After admission, residents weights must be taken within 24 hours of admission, and after admission, taken monthly;
c) All resident weights are to be completed and entered into PCC by the 10th of the month;
d) A consistent scale must be used for each weigh in;
e) Methods used to determine each residents weight are to be noted in PCC; and
f) If a resident has a loss/gain of 2.0 kg over a month, a reweigh must be done immediately or within 48 hours.

The licensee failed to ensure that the areas identified in their weight and height policy, listed above, were complied with for resident #03, #06, and #09.

i) Resident #03's clinical record revealed that: no weight was recorded upon admission, monthly weights were not taken in May and July 2015, a monthly weight was not completed by the 10th of the month in April 2015, consistent scales were not used for each weigh in, methods used to determine the resident's weights were not consistently noted; and, a re-weigh was not completed in March, April, and May 2015, when the resident had a loss/gain of 2.0 kg over a month. PSW's and registered nursing staff reported that weights were to be taken on admission and monthly thereafter by the 10th day of the month, consistent scales and type used be documented, and re-weights to be

completed immediately if the resident presented a significant change in weight. PSWs and registered staff confirmed that steps required for monitoring weight, as outlined in their policy, were not followed for resident #03.

ii) Resident #06's clinical record revealed that: monthly weights were not taken in September and October 2014, January 2015 and February 2015, monthly weights were not completed by the 10th of month in November 2014, March and May 2015, methods used to determine the resident's weights were not consistently noted, and a re-weigh was not completed in April and May 2015 when the resident had a loss of 2.0 kg over a month. PSWs familiar with the resident confirmed that weights were to be taken and recorded monthly by the 10th of the month, and the type of scale used documented, and that steps were not followed the resident. PSWs were unable consistently confirm when reweighs were to occur. The RD confirmed that steps required for monitoring weight, as outlined in the policy, were not followed for resident #06.

iii) Resident #09's clinical record revealed that: a monthly weight was not taken in January 2015, monthly weights were not completed by the 10th of the month in March and April, 2015; and, methods used to determine the resident's weights were not consistently noted. Interviews with PSWs confirmed that weights were to be taken and recorded monthly by the 10th of the month, and the type of scale used documented. PSWs and the RD confirmed that the steps required for monitoring weight, as outlined in the policy, were not followed for resident #09. (585) [s. 8. (1) (b)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home furnishings and equipment were maintained in a safe condition and in a good state of repair.

A) During initial tour of the home on July 9, 2015 and July 22, 2015, the following areas were not observed in a good state of repair:

i) Tiled walls and floors in the Heritage South shower area were observed with heavy amounts of hard water scale,
ii) Tiled floors in the Heritage North shower area were observed with heavy amount of hard water scale,
iii) Tiled floors in the Twin River Court shower area were observed with heavy amounts of white scale built up,
iv) The rim of the tub and tub chair in the Sunrise Court tub room was observed with white scale build up, and
v) Three seated chair scales in the Heritage tub rooms were observed with heavy amounts of white scaling.

Interview with maintenance staff confirmed that the areas listed above had evidence of heavy hard water scale. Interview with the Administrator confirmed that the home was trialing a new cleaning product for the hard water stains; however, was showing little to no effect.

B) On July 9, 2015, the carpets throughout four nursing home areas were noted to be stained. Review of the homes Carpet Cleaning Schedule for July 2015, identified that carpets were cleaned as scheduled; however, interview with a housekeeping staff from one home area confirmed that regularly scheduled carpet cleaning did not remove some of the stains. Interview with the Administrator confirmed that the home was aware of the condition of the remaining carpets and indicated that they were to be removed; however, did not yet have a time line determined for when they would be replaced. [s. 15. (2) (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 ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD 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. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Throughout the course of the inspection, resident #03 was observed using a PASD. Interview with direct care staff revealed that the resident used the PASD daily for safety and positioning; however, review of the plan of care did not identify that the resident used the PASD. Interview with registered staff confirmed that the PASD, used daily by the resident to assist with safety and positioning, was not included in the plan of care. [s. 33. (3)]

2. The licensee failed to ensure the use of PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following were satisfied:
1. Alternatives to the use of a PASD had been considered and tried where appropriate.
3. The use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, or any other person provided for in the regulations.
4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

A) On two dates in July 2015, resident #80 was observed in bed with two three quarter bed rails raised. Review of the clinical record indicated there was no assessment completed to determine the reason for the use of the bed rail, nor any documented consent or approvals for its use. Registered staff confirmed that the resident's bed rails were not assessed to determine if they were being used as a PASD or a restraint, nor did they have documented consent or approval for the bed rails in place. (581)

B) On two dates in July 2015, resident #81 was observed sitting in a tilted wheelchair with a lap belt fastened. Review of the clinical record indicated there was no assessment completed to determine the reason for the use of the tilt wheelchair or lap belt, nor any documented consent or approvals for their use. Registered staff confirmed that the resident's tilt wheelchair and lap belt were not assessed to determine if they were being used as a PASD or a restraint nor did they have documented consent or approval for the tilt wheelchair and lap belt in place. (581) [s. 33. (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 ensuring that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care; and, the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if 1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 3. The use of the PASD has been approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations, and 4. The use of the PASD 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, to be implemented voluntarily.

WN #9: 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 are 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

The licensee failed to ensure that resident #03 and #06's significant weight changes were assessed using an interdisciplinary approach, that actions were taken and outcomes evaluated.

The home's policy, 'Monitoring Residents Weight and Height', effective July 2013, stated weights were to be taken and recorded by the 10th day of the month, reweighs were to be taken and documented immediately or within 24 hours with a change of 2.0 kilograms in one month, and residents who lost or gained a significant amount of weight were to be followed up by the RD immediately.

i) Resident #03 was identified as high nutritional risk, as indicated in their plan of care.

In April 2015 the resident's clinical record indicated they had a loss of 7 kilograms between March and April 2015; a change of 8.9%. The RD completed an assessment of the April weight change in May 2015, stating that they would monitor their May weight. In May 2015, no weight was documented in the clinical record. Interview with a PSW confirmed the resident was not reweighed in April 2015 when the significant change was noted, nor was a weight recorded in May 2015. In June 2015, the resident's weight was recorded and indicated they had a weight change of 17.5% over three months. A reassessment by the RD did not occur 20 days following the weight measurement. This was confirmed by the RD.

ii) Resident #06 was identified as high nutritional risk, and significantly underweight as indicated in their plan of care.

On April 2, 2015, the resident's clinical record indicated they had a loss of 2.4 kilograms between March and April 2015; a change of 5.7%, with no reweigh. The RD completed an assessment in April 2015, and noted they would monitor the May weight.

In late May 2015, the resident's weight was recorded and indicated they had a loss 6.7 kilograms between April and May 2015; a change of 15.6%, with no reweigh. The RD completed an assessment in late May 2015, noted that no reweigh was obtained, and they would re-assess weight in June, when available.

In early June 2015, the resident's weight was recorded and indicated a loss of 11.6% over three months, and gain of 13.1% over 6 months. A reassessment by the RD did not occur until late June 2015. This was confirmed by the RD. PSWs were interviewed and reported weights were to be taken within the first 10 days of the month, and provided inconsistent responses for criteria of when a resident would require a reweigh. A PSW confirmed that weight was not documented within the first 10 days of the month in May 2015. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 and 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, and
3. A change of 10 per cent of body weight, or more, over 6 months, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that planned menu items were offered and available at each meal.

A) On July 9, 2015, during lunch in the Sunrise Court dining room:

i) Pureed roast beef sandwich and beet onion salad was not observed available for meal service. Interview with the dietary aide serving confirmed they did not have the items present, and had to contact other staff to obtain them.

B) On July 14, 2015, during lunch meal service in Sunrise Court dining room:

i) Whole wheat bread and chocolate ice cream was on the planned menu. Regular texture bread was not observed served to residents. The dietary aide distributing dessert was observed to run out of chocolate ice cream. The dietary aide was observed speaking with a resident, informing them they ran out of ice cream and was only able to offer fruit.

ii) Resident #63 was provided a therapeutic dessert, and not offered other dessert options. Staff confirmed the resident was capable of making their own food choices, and was not offered all dessert menu options.

C) On July 15, 2015, in the Grand River dining room:

i) Puree pineapple was on the planned menu. No puree pineapple was available at meal service, as confirmed in an interview with the dietary aide.

ii) Resident #64 was provided a therapeutic dessert, and not offered the other dessert options. Staff confirmed the resident was capable of making their own food choices, and was not offered all dessert options.

D) On July 15, 2015 during supper meal service in Sunrise Court dining room:

i) Puree pie was on the planned menu. The dessert trays were examined and did not contain puree pie, as confirmed in an interview with the dietary aide.

E) Resident #42, who required a puree diet and required assistance from staff with eating, was not provided with planned menu items at multiple meals. The resident was at high nutritional risk, as confirmed by the FSM.

i) On an unspecified date in July 2015, the resident only received puree egg and peas, and did not receive puree bread as it was not available, as confirmed by the dietary aide.

ii) On an unspecified date in July 2015, the resident received puree bread and vegetable as their meal. The dietary aide stated identified the puree bread in the steam table as possibly as the ham sandwich, however could not confirm this as meat was not separate from the bread. The item was sampled did not contain a taste or flavour of ham. [s. 71. (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 and ensuring that planned menu items are offered and available at each meal, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system, at a minimum, provided for (d) preparation of all menu items according to the planned menu.

A) On July 9, 2015, spanish omelet was on the planned menu for lunch. During the meal, a pan of cooked blended egg was observed, cut into rectangular portions approximately 3/4 inches high, 2.5 inches long, and 2 inches wide. The portions appeared small, and cut in inconsistent sizes. Review of the recipe indicated that the omelets were to be prepared individually, by portioning liquid egg on a hot griddle, and cooking into long, oval shaped omelets. The FSM confirmed the menu item was not prepared according to the planned menu, and that the actual portion sizes served were not comparable to the recipe, which compromised the meal's nutritional adequacy. [s. 72. (2) (d)]

2. The licensee failed to ensure that all food and fluids in the food production system were prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality.

A) On July 9, 2015, during lunch in the Sunrise Court dining room, puree beet and onion salad, as well as roast beef sandwich was served. The puree items appeared runny, and pooled when plated.

B) On July 14, 2015, during lunch meal service in the Sunrise Court dining room, puree bread and minced chicken was served. The puree bread appeared runny, and the minced chicken resembled a puree texture, and was sticky, as confirmed by the dietary aide.

C) On July 15, 2015, during lunch in the Grand River dining room, puree quiche and sweet potato was served. The puree quiche appeared dry, and required a utensil to cut through the food, and the sweet potato was sticky, as confirmed by the dietary aide.

D) On July 15, 2015, during supper in the Sunrise Court dining room, puree asparagus appeared runny when served.

The Food Service Manager reported in an interview that puree items were to be prepared, stored and served to a consistency that was smooth and hold its shape, and minced items were to have visible texture and be moist. The FSM confirmed that runny, sticky, foods, and items served at an inappropriate consistency would impact its appearance, taste, food quality and safety. [s. 72. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring all food and fluids in the food production system are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 77. Food service workers, minimums

Specifically failed to comply with the following:

s. 77. (1) Every licensee of a long-term care home shall ensure that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2) for,
(a) the preparation of resident meals and snacks; O. Reg. 79/10, s. 77 (1).
(b) the distribution and service of resident meals; O. Reg. 79/10, s. 77 (1).
(c) the receiving, storing and managing of the inventory of resident food and food service supplies; and O. Reg. 79/10, s. 77 (1).
(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service. O. Reg. 79/10, s. 77 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there were sufficient food service workers for the home to meet the minimum staffing hours in accordance to what is outlined in O. Reg 79/10 s. 77 (2).

The home had a licensed bed capacity of 132 beds, which was confirmed by the Administrator.

Based on O. Reg 79/10 s. 77 (2), the minimum staffing hours for food service workers required by the licensee were as follows:

M = A x 7 x 0.45, where 'M' was the minimum number of staffing hours per week, and 'A" was the licensed bed capacity in the home, if the home was at an occupancy of 97% or

more. At an occupancy of 97% or more, the licensee was required to provide a minimum of 415.80 food service worker hours per week.

A) The home's scheduling documentation which identified shifts and hours worked by food service workers and cooks, was reviewed from April to July 2015, and revealed that the home was not meeting the minimum requirements for dietary staffing hours for seven consecutive weeks in the months of April, May and June, 2015.

i) In the week of April 20-26, 2015, 407.50 food service worker hours were provided, resulting in a shortage of 8.30 hours.
ii) In the week of April 26- May 3, 2015, 404.25 food service worker hours were provided, resulting in a shortage of 11.55 hours.
iii) In the week of May 4 – 10, 2015, 415.25 food service worker hours were provided, resulting in a shortage of 0.55 hours.
iv) In the week of May 11 – 17, 2015, 382.75 food service worker hours were provided, resulting in a shortage of 33.05 hours.
v) In the week of May 18 - 24, 2015, 399.00 food service worker hours were provided, resulting in a shortage of 16.80 hours.
vi) In the week of May 25 - 31, 2015, 399.00 food service worker hours were provided, resulting in a shortage of 16.80 hours.
vii) In the week of June 1 - 7, 2015, 393.75 food service worker hours were provided, resulting in a shortage of 22.05 hours.

Multiple FSW's, a full-time cook, and the FSM reported experiencing shortages in the department on average once a week. The Administrator reported that a new staffing plan was implemented in the department in late March 2015 to assist the home in meeting the minimum staffing requirements; however, confirmed that they did not meet the requirements during the identified time periods. [s. 77. (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 and ensuring that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2) for, (a) the preparation of resident meals and snacks; (b) the distribution and service of resident meals; (c) the receiving, storing and managing of the inventory of resident food and food service supplies; and (d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures developed as part of their program of housekeeping were implemented for cleaning of resident bedrooms, including floors, furnishings, and contact surfaces.

A) The home's policy, "Housekeeping Routine - Policy 3.5", effective March 2011, identified that once a week, staff were to complete a thorough clean of residents rooms, which involved dusting the top of wardrobes and dressers, and wet mopping the bedroom and bathroom floor.

On an unspecified date in July 2015, a dry brown solid residue was noted on the floor beside resident #12's bed, as well as significant amounts of dust on the top of their wardrobe, bedside and end table, and dry brown solid residue on the floor. The following day, a housekeeper was observed providing a deep clean to the resident's room. After the cleaning, the dust was still present on multiple surfaces throughout the room and bathroom, under furniture, as well as the brown residue on the floor. The housekeeper reported the home's expectation was to clean all the surfaces during the deep clean, which they confirmed was not done. [s. 87. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, procedures are developed and implemented for, (a) cleaning of the home, including, (i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, to be implemented voluntarily.

WN #14: 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 a PASD used under section 33 of the Act, was applied by staff in accordance with the manufacturer's instructions.

i) On an unspecified date in July 2015, resident #81 was observed sitting with a lap belt applied more than six finger widths from their torso. A RPN and PSW confirmed that the lap belt was too loose and the PSW adjusted the seat belt to two finger widths from the torso.

ii) On an unspecified date in July 2015, resident #81 was observed sitting with a lap belt applied more than ten finger widths from their torso. Registered staff confirmed the lap belt was too loose and adjusted the belt to two finger widths from the torso. Registered staff confirmed and that the manufacturers' instructions stated that the lap belt was to be applied two finger widths from the resident's torso. [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 and ensuring that a PASD used under section 33 of the Act, is applied by staff in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication and response system was available in every area accessible by residents.

It was observed that the home did not have a resident-staff communication and response system located in the Rose Garden or in the secured outdoor areas off Sunrise Court, Twin River Court and Family Room Patio used by residents. Interview with the Administrator confirmed that a communication and response system was not available in the identified areas, which residents accessed. [s. 17. (1) (e)]

WN #16: 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:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

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

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

Review of the written plan of care for resident #08 did not indicate the resident's sleep patterns and preferences. PSWs and registered staff were interviewed and reported the resident's sleep patterns and preferences. Registered staff confirmed there was no interdisciplinary assessment of the resident's sleep patterns and preferences. [s. 26. (3) 21.]

2. The licensee failed to ensure that the registered dietitian, who was a member of the staff of the home, complete a nutritional assessment for the resident on admission, in time frame as outlined under O. Reg 79/10 s. 25 (1)(a).

Resident #03 was admitted to the home in January 2015. Review of the resident's clinical record revealed that an RD did not complete a nutritional assessment and hydration assessment until 16 days following admission. This was confirmed by the RD. [s. 26. (4) (a),s. 26. (4) (b)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) 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. 31 (3).

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) 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. 31 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the staffing plan included a back-up plan for nursing and personal care staffing that addressed situations when staff, including the staff who provided the nursing coverage required under subsection 8 (3) of the Act, could not come to work.

Throughout the course of the inspection, interviews were held with seven direct care staff (length of employment varying from new employee to approximately 20 years of service, on three home areas), who were unaware if the home had a back up plan for nursing and personal care when staff could not come to work. Two of the seven staff members identified that in a situation when they work short staffed, the resident's came first. Interview with the Administrator identified that the home did not have a written back up plan for nursing and personal care staffing. [s. 31. (3) (d)]

2. The licensee failed to ensure that the written record annual evaluation of the staffing plan included a summary of the changes made and the date that those changes were implemented.

Review of the annual evaluation of the nursing staffing plan from January 2015 did not include a summary of changed made and the dates those changes were implemented. Interview with the Administrator identified that the home discussed staffing at monthly management meetings and staffing levels were constantly adjusted, which are documented within the monthly management meeting minutes; however, not included as part of the annual evaluation of the staffing plan. [s. 31. (4)]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee did not respond in writing within ten days of receiving Family Council advice related to concerns or recommendations.

A review of the Family Council Meeting Minutes from October 21, 2014 to June 16, 2015, identified that not all concerns or recommendations received were responded to in writing within ten days.

Meeting minutes from March 17, 2015, included several concerns:
i) not enough parking in the back lot,
ii) phone calls to the facility not being answered,
iii) protocol for leaving a phone messages,
iv) whether the home had a procedure for painting resident rooms, and
v) if a spring clean was completed in the residents' rooms, including the dusting of baseboards and moving furniture.

Review of records revealed that the concern regarding parking was not responded to in writing until June 29, 2015, and all other concerns raised from the March meeting were not responded to in writing until April 14, 2015. The Administrator confirmed that responses to the above noted issues were not responded to in writing within 10 days. [s. 60. (2)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, the following elements: course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

On July 9, 2015, at lunch in the Sunrise Court dining room, multiple residents were served dessert by a dietary aide before they completed their main course.

On July 15, 2015, at supper in the Sunrise Court dining room, multiple residents were served dessert before they completed their main course.

The diet list in the servery was reviewed and did not indicate the residents were to be served multiple courses at meals. The Food Service Manager confirmed the residents were only to be served course by course. [s. 73. (1) 8.]

2. The licensee failed to ensure that no person simultaneously assisted more than two residents who needed total assistance with eating or drinking.

Resident #03 and #66 required extensive to total assistance with eating, and resident #65 required total assistance with eating. On an unspecified date in July 2015, a PSW was observed providing total assistance to resident #03 and #65, and another PSW was providing total assistance to resident #66. Both staff reported the residents required total assistance with eating for that meal. The PSW assisting #66 left partway through the meal to deliver trays, and the PSW assisting #03 and #65 was left to assist resident #66. Ten minutes later, another PSW came to help feed resident #66. Both staff confirmed no person was to simultaneously assist more than two residents who required total assistance. This was confirmed by Registered nursing staff. [s. 73. (2) (a)]

Issued on this 2nd day of September, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LEAH CURLE (585), CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581)
Inspection No. / No de l'inspection :	2015_343585_0015
Log No. / Registre no:	H-002833-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 18, 2015
Licensee / Titulaire de permis :	PARK LANE TERRACE LIMITED 284 CENTRAL AVENUE, LONDON, ON, N6B-2C8
LTC Home / Foyer de SLD :	PARK LANE TERRACE 295 GRAND RIVER STREET NORTH, PARIS, ON, N3L-2N9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DEBORA SAVILLE

To PARK LANE TERRACE LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee must ensure that home's range of continence products includes a pull up type product, to promote resident #08, resident #45 and resident #46's comfort, ease of use, and continued independence, that is paid for by the home.

Grounds / Motifs :

1. The plan of care for resident #08 identified that the resident was frequently incontinent of bladder related to mixed functional incontinence and required supervision to limited assistance, but also toileted themself at times. In June 2015, the resident was noted as having cognitive difficulty using the homes continent care products and pull ups were trialed "to maintain toileting and ease of product", as confirmed with registered staff. Interview with the resident's Power of Attorney (POA) confirmed that they were instructed that the home did not provide a pull up type product; therefore, the family was paying for a pull up product to try and maintain the resident's independence with toileting. Interview with the Personal Support Worker (PSW) staff confirmed that the resident was unable to use the home's continent pads and would be unable to apply a brief; therefore, the home did not provide a continent care product that promoted the resident's comfort, ease of use, and independence.

2. The plan of care for resident #45 identified that they were frequently incontinent of bladder related to functional incontinence and was able to self toilet successfully with the use of a pull up type product. Interview with direct care staff confirmed that the resident was not cognitively able to use the continent pads or briefs provided by home. Interview with the family confirmed that they were instructed that the home did not provide a pull up type product, therefore, they had been paying for a pull up type product to try and maintain the resident's independence with toileting. The home's range of continence products did not include one that promoted resident's #45 comfort, ease of use, and independence with toileting.

3. The plan of care for resident #46 identified that they were occasionally incontinent of bladder related to urge and used a pull up type product to "aide in toileting self". Interview with direct care staff confirmed the resident used pull ups supplied by family, which allowed the resident to toilet themself independently, as staff did not have to assist with product placement. Interview with the family confirmed that the resident was comfortable with and able to use a pull up type product and since the home did not provide a pull up, was paying for the product. The home's range of continence products did not include one that promoted resident's #46 comfort, ease of use, and independence with toileting.

4. Interviews with three TENA representatives and the Director of Care (DOC) confirmed that homes range of continent care products did not include a pull up type product; therefore, resident and families requiring or requesting a pull up type product were given the option to use the home's continent pad insert, brief, or pay for a pull up type product on their own. (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2015

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

Order / Ordre :

The licensee shall complete the following:

1. Develop a comprehensive bed safety assessment tool using as a guide the US Federal Food and Drug Administration document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".

2. An interdisciplinary assessment of all residents, including resident #08, #10 and #80, using the bed safety assessment tool shall be completed and the results and recommendations of the assessment shall be documented.

3. Update all resident health care records to include why bed rails are being used, how many are to be used and any accessories that are required to mitigate any identified entrapment or safety risks.

4. Educate all health care staff with respect to when to apply bed rails for each resident, why they are being applied and general bed safety hazards.

Grounds / Motifs :

1. r. 15. (1)(a) previously issued as a VPC in April 2014. (581)

2. The following residents had not been assessed according to prevailing practices adopted by Health Canada in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003" developed by the US Food and Drug Administration, which outlined that decisions to use or to discontinue the use of a bed rail should be made in the context of an individualized patient assessment using an interdisciplinary team with input from the patient and family or the patient's legal guardian.

i) On an unspecified date in July 2015, one three quarter bed rail was observed raised on resident #08's bed. A review of the written plan of care did not indicate they required the use of one three quarter bed rail. PSW's and registered staff stated that the resident had one three quarter bed rail raised when in bed and was used for turning and positioning. A review of the resident's plan of care did not include an assessment of the bed rails being used and this was confirmed by the registered staff.

ii) On unspecified dates in July 2015, resident #80 was observed in bed with two three quarter bed rails raised. Review of the written plan of care indicated the resident required the use of two three quarter bed rails raised when in bed for positioning. PSWs and registered staff stated they used the bed rails for turning and positioning. A review of the resident's plan of care did not include an assessment of the bed rails being used and this was confirmed by the registered staff. (581)

3. The home did not take steps to mitigate the risk of entrapment for failed zones for the following residents:

i) Resident #08's plan of care identified that they used a three quarter rail daily to assist with turning and positioning while in bed. Review of the home's Bed Entrapment Audit, dated October 2014, identified that the bed system for the resident failed entrapment zones three and four, and no accessory observed to be in place to mitigate the identified entrapment zones.

ii) Resident #10's plan of care identified that they used two three quarter rails daily to assist with safety and positioning while in bed. Review of the home's Bed Entrapment Audit, dated October 2014, identified that the bed system for the resident failed entrapment zones three and four, and no accessory observed to

be in place to mitigate the identified entrapment zones.

iii) Resident #80's plan of care identified that they used two three quarter rails daily when in bed for positioning and mobility when in bed. Review of the home's Bed Entrapment Audit dated October 2014, identified that the resident used an air mattress and the bed system for the resident failed entrapment zones two, three and four. No accessory observed to be in place to mitigate the identified entrapment zones.

The Administrator confirmed in an interview that the bed rails for resident #08, #10 and #80 were tightened; however, the bed systems had not been re-tested for failed zones. Steps had not been taken to prevent entrapment related to failed zones two to four for resident #08, #10 and #80's bed systems. (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 20, 2015

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

Order / Ordre :

The licensee must ensure that drugs stored in an area or medication cart are secured and locked when unattended or not in use by persons who may dispense, prescribe or administers drugs within the home.

Grounds / Motifs :

1. On July 9, 2015, at 1215 hours, a medication cart was found unlocked outside of dining room in Heritage Green. The Registered Practical Nurse (RPN) was in the dining room with the residents. The Long-Term Care Homes (LTCH) Inspector was able to open and close medication cart drawers without the nurse being aware. Interview with the nurse confirmed the medication cart should be locked when unattended. (528)

2. On July 10, 2015, during breakfast meal service, a medication cart was found unlocked and unattended in the hallway outside of the Heritage Green dining room. The registered staff was administering medications in the dining room. The LTCH Inspector was able to open and close the drawers without registered staff being aware. Interview with registered staff confirmed that the cart was left

open when it was unattended and immediately locked the cart. (528)

3. On July 10, 2015, at 0950 hours, the nursing station and medication room on Sunrise Court was observed open. The medication cart in medication room was also unlocked. Registered staff was administering medications in a resident's room and the second registered staff was in the staff room on the computer. Four cognitively impaired residents were sitting outside of nurses station. The LTCH Inspector was able to enter the medication room and open medication cupboards and medication cart drawers without the registered staff being aware. Interview with both registered staff revealed that they were unaware the medication room and cart were unlocked and the medication room was immediately locked. (528)

4. On July 15, 2015, during lunch service, registered staff were administering medications. The medication cart was unattended and unlocked in the hallway outside of the dining room, two residents were making their way in and out of the dining room. The LTCH Inspector was able to open and close the medication cart drawers without registered staff being aware. When registered staff exited the dining room, they confirmed the cart was left unattended and unlocked and the cart was locked immediately. (528)

5. On July 15, 2015, over lunch meal service in the Grand River dining room, a medication cart was observed unlocked and unattended while an RPN was distributing medication. The LTCH Inspector was able to open and close drawers on the cart, with the registered staff unaware. The RPN confirmed the medication cart was unlocked. (585)

6. On July 20, 2015, at 0840 hours, the medication cart in the dining room on Grand River Court was unlocked and unattended. Eight residents were finishing breakfast and registered staff was not in the dining room. The cart was left unlocked for approximately five minutes. Interview with the RPN confirmed that the medication cart was left unattended and unlocked, while they were at the nursing station. (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2015

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 : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Grounds / Motifs :

1. Previously issued as a VPC in May 2015

2. In November 2014, resident #80 sustained a fracture while being transferred. Review of the written plan of care and the Safety in Ambulation, Lifting and Transferring (S.A.L.T.) assessment indicated they were transferred with one or two person assistance with a transfer belt. Interview with the PSW who assisted the resident with the transfer stated they did not use a transfer belt. Registered staff confirmed that the staff did not use safe transferring and positioning devices or techniques when assisting resident #80. (581)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 18th day of August, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Leah Curle

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