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

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Jun 8, 2015	2015_217137_0021	008689-15	Resident Quality Inspection

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF RIVERSIDE GLEN
60 WOODLAWN ROAD EAST GUELPH ON N1H 8M8

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

MARIAN MACDONALD (137), BONNIE MACDONALD (135), RUTH HILDEBRAND (128)

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): May 11-15, 19-22 and 25-27, 2015.

The following inspections were conducted during the Resident Quality Inspection (RQI): Critical Incident System Log # 004638-15; Critical Incident System Log # 007252-15; Complaint Log # 003522-15.

During the course of the inspection, the inspector(s) spoke with General Manager, Interim Assistant General Manager, Director of Nursing Care, Assistant Director of Nursing Care, Director of Recreation, Director of Environmental Services, Director of Food services, Assistant Director of Food services, Administrative Assistant, two Scheduling Coordinators, three Resident Assessment Instruments/Quality Improvement(RAI/QI) Coordinators, three Neighborhood Coordinators, two Registered Nurses, 12 Registered Practical Nurses, one Behaviour Supports Ontario (BSO)/Restorative Care Coordinator, one Kinesiologist, one Quality of Life Lead, one Chaplain, three Registered Dietitians, one Music Therapist, two Physiotherapy Assistants, 19 Personal Care Aides, one Housekeeping Aide, one Recreation Aide, one Volunteer, one Dietary Aide, one Maintenance Worker, Representatives from the Residents' and Family Councils, 40 + Residents and three Family Members.

The Inspectors also toured all resident home areas, common areas, medication storage area, observed dining service, care provision, resident/staff interactions, recreational programs, medication administration, reviewed residents' clinical records, relevant policies and procedures, call bell response records, staff education records and various meeting minutes.

The following Inspection Protocols were used during this inspection:

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

During the course of this inspection, Non-Compliances were issued.

- **15 WN(s)**
- **9 VPC(s)**
- **6 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 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. A written notification and a voluntary plan of correction were previously issued on November 27, 2014, under Log # L-001792-12 and Inspection # 2012_171155_0016 and on April 22, 2014, under Log # L-000426-14 and Inspection # 2014_228171_0004 related to the home, furnishings and equipment not being maintained in a safe condition and in a good state of repair.

Observations, during the initial tour and throughout the RQI, revealed identified deficiencies including:
a) Damaged and paint chipped doors, door frames, walls and baseboards in over 25 resident rooms, as well as in common areas, in all six Neighborhoods.
b) Wooden hallway handrails damaged, gouged and splintered, with sharp areas of wood exposed posing a potential risk to residents, throughout all six Neighborhoods.
c) Dead insects in hallway and dining room light fixtures in Nichol, Puslinch and Eramosa Neighborhoods.
d) Damaged wallpaper in hallways of Nichol, Erin, Puslinch and Mapleton Neighborhoods.
e) Front entrance mat secured to floor with red and yellow duct tape.
f) Damaged and discolored wall tiles and floor in Nichol SPA tub room.
g) Shower curtain loose from hooks and toilet grab bar loose at the wall in Eramosa SPA.
h) Sofa table and coffee tables damaged in Arthur and Mapleton lounges.
i) Black gouge marks and sticky film build-up on dining room floors in Mapleton and Eramosa.
j) Stained ceiling tiles near Mapleton nursing station.
k) Caulking along floor tile at shower head with black mould-like growth in Mapleton shower room.
l) Finish/paint damaged on metal gate and handrails in front foyer stairwell, as well as bed rails in identified residents' rooms.

A tour was conducted with the Interim Assistant General Manager and the Director of Environmental Services.
Both confirmed the identified deficiencies, as well as the expectation that home, furnishings and equipment be maintained in a safe condition and in a good state of repair.
The Director of Environmental Services also confirmed that the home is working on a preventive maintenance schedule but currently there is no schedule in place. [s. 15. (2) (c)]

2. The licensee failed to ensure that the home, furnishings and equipment were not maintained in a safe condition and in a good state of repair when the following was observed during a lunch service:

2/3 (66 per cent) of the lipped plates had finish removed and could no longer be sanitized. One plate noted to have food like debris stuck to the plate surface where the surface had been cut.
7/11 (63.6 per cent) of the eight ounce plastic beverage glasses were stained brown. Three of the 11 glasses were cracked and could no longer be sanitized properly.

During an interview the Director of Food Services confirmed her expectation that the home's furnishings and equipment were to be kept in a safe condition and in a good state of repair. [s. 15. (2) (c)]

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. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. A written notification of non-compliance and a voluntary plan of correction were previously issued on January 30, 2014 under Log 3 L-000104-14 and Inspection # 2014_226192_0003, April 22, 2014 under Log # L-000426-14 and Inspection # 2014_228172_0004 and on October 14, 2014 under Log 3 L-005184-14 and Inspection # 2014_183135_0085 related to not all staff participating in the implementation of the infection prevention and control program.

Observations, throughout the RQI, revealed identified infection prevention and control risks in shared resident rooms/washrooms and SPA tub/shower rooms.

a) Personal care items, such as toothpaste, toothbrushes, combs, hair brushes, electric razors, bedpans, urinals, urine collection hats, etc., were not labeled and stored properly in twelve (12) identified shared resident washrooms.
b) SPA tub/shower rooms on Nichol, Erin and Puslinch Neighborhoods contained unlabeled toothpaste, combs, body wash, moisture therapy lotions, used bar soaps, body spray, roll on deodorants, shaving cream, hairspray, shampoo and conditioner and Gold Bond body powder,
c) Steno chairs heavily soiled at Erin Neighborhood nursing station.
d) Nail clippings were observed in nail clipper drawers in Nichol shower room and Puslinch tub room. The tray for disinfecting nail clippers was rusted and soiled.
e) A review of the Daily Infection Control Surveillance sheets, during an 18 day period, to be completed by registered staff on each shift, revealed the following:
Mapleton - initials missing for eight night shifts
Eramosa - initials missing for six day shifts, four evening shifts and ten night shifts.
Arthur - initials missing for one day shift and three night shifts.
Erin - initials missing for one day shift and seven evening shifts.
Puslinch - initials missing for five day shifts, five evening shifts and one night shift.
Nichol - no initials missing.

A RAI/QI Coordinator confirmed initials were missing and the expectation is that registered staff complete the Daily Infection Control Surveillance sheets on each shift.

A tour was conducted with the Assistant Director of Nursing Care, the Director of Environmental Services and RAI/QI Coordinator/Infection Control designate.
All three confirmed that the identified personal care items were not labeled and/or stored properly, posing a potential infection prevention and control risk to residents, as well as the expectation that all staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

2. During pm snack service in an identified Neighborhood, a student was observed not to be practicing proper hand hygiene when serving residents Danish with his/her fingers, instead of the tongs provided on the snack cart.

In an interview, the Director of Food Services confirmed her expectation that staff and volunteers participate in the implementation of the infection prevention and control program, when serving resident snacks. [s. 229. (4)]

3. During a medication administration observation, a registered staff member did not utilize hand hygiene practices before or after performing a nursing measure on an identified resident, as well as between administering medications to other residents. [s. 229. (4)]

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. 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).

Findings/Faits saillants :

1. A written notification of non-compliance and a Compliance Order were previously issued on March 17, 2014 under Log # L-000126-14 and Inspection # 2014_202165_0005, as well as on May 26, 2014 under Log # L-000426-14 and Inspection # 2014_228172_0004 related to the staffing plan, which were previously returned to compliance.

The licensee failed to ensure that the staffing plan provides for a staffing mix that is consistent with residents’assessed care and safety needs.

Interviews and record reviews, of the call bell response records for an identified month, revealed:
1) Resident # 011 shared that sometimes the call bells do not get answered in a timely manner on an identified Neighborhood.
A review of the call bell response records indicated, on an identified date, the call bell was activated at 18:41:49 and canceled in 26:36 minutes.

2) Resident # 012 shared there is not enough staff available in the evening. Sometimes residents have had to wait over a half an hour to be put to bed in the evening on an identified Neighborhood.
A review of the call bell response records indicated, on an identified date, the call bell was activated at 20:15:12 and canceled in 26:55 minutes.

3) Resident # 031 shared having to wait a long time to go to bed as they start at the other hallway first and the resident usually waits at least a half hour or longer on an identified Neighborhood.
A review of the call bell response records indicated, on one identified date, the call bell was activated at 19:01:08 and canceled in 27:59 minutes and on another identified date, the call bell was activated at 18:08:50 and canceled in 28.21 minutes.

4) Resident # 030 shared having to consistently wait for a half hour or longer for staff to respond to the call bell.
A review of the call bell response records on an identified Neighborhood indicated there were fifty-six incidents where Resident # 030 waited over twenty-minutes for a response to the call bell, including nine incidents where the response time ranged from 1 hour + 1:06 minutes to 1 hour + 34.31 minutes.

5) A review of the call bell response records for an identified Neighborhood revealed there were 125 documented entries where the call bell response time was over twenty minutes and on another identified Neighborhood there were sixty-seven (67) documented entries where the call bell response time was over twenty minutes.

6) A concern was raised at the Residents' Council Meeting on October 30, 2014, related to response time for bells. Management was asked to check how long bell response time was on Erin, Puslinch and Arthur during 3-11 shift. The response from the Leadership

team was "a new policy has been initiated and appropriate access given to the Neighborhood Coordinators to check call bell response times on a weekly basis".

7) A review of the staffing plan evaluation, dated February 5, 2015, revealed:
A complete review of the staffing levels at Riverside Glen related to care levels has been undertaken over the past month. In particular, the review has been cross referenced with the number of complaints received by residents/families relating to answering of call bells and the provision of a pleasurable dining experience given the amount of assistance required by our frail population.

8) A proposed call bell response policy was developed on November 20, 2014, to audit and monitor call bell response time.
The Interim Assistant General Manager and two registered staff members confirmed the policy has not been implemented and the expectation is that call bell response times be audited and monitored, as well as call bells responded to in a timely manner. [s. 31. (3)]

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. 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. A written notification of non-compliance and a voluntary plan of correction were previously issued on April 14, 2015, under Log # 001518-15 and Inspection # 2015_226192_0018, as well as on April 14, 2014, unfer Log # L-000405-14 and

Inspection # 2014_226192_0012, related to the home's weight policy not being complied with.

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

The home's policy for Weight and Height Monitoring reviewed January, 2014 states the following:

2. All Residents will be weighed on admission, re-admission, monthly and as deemed necessary. PCA is responsible for completing the Resident's weight by the 7th of each month.

Record review revealed that residents’ weights were not taken monthly as follows:

In one identified Neighborhood, 10 of 32 (31.25 per cent) of the residents did not have their weight taken in February, 2015.
In another identified Neighborhood, 8 of 32 (25 per cent) of the residents did not have their weight taken in April 2015.

The home’s policy for Weight and Height Monitoring January, 2014 also states:

3. PCA Weight Responsibilities- the weight will be recorded on the Monthly Weight Record form found in Gold Care under the demographic report for monthly vital sign weight batch form.

Record review revealed residents weights were not recorded on the Monthly Weight Record form found in Gold Care as follows:

In one identified Neighborhood, 27 or 90 per cent of the residents did not have their weights recorded in Gold Care in February, 2015.
In another identified Neighborhood, 23 or 71.8 per cent of the residents did not have their weights recorded in Gold Care in April, 2015

In an interview the home’s Registered Dietitian confirmed that residents' weights are not always available monthly, to assess residents' nutritional status.

During an interview, the Assistant Director of Nursing Care confirmed his expectation that

the home's Weight Monitoring policy is complied with ensuring residents weights are taken and documented monthly. [s. 8. (1) (b)]

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 O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. A written notification of non-compliance and a voluntary plan of correction were previously issued on October 19, 2012, under Log # L-001402-12 and Inspection # 2012_183135_0007.

The licensee has failed to ensure that proper techniques were utilized to assist residents with eating, including safe positioning of residents who required assistance.

A Personal Care Aide was observed standing to assist Resident # 026, with drinking a beverage, at a lunch meal, in an identified Neighborhood. The resident was not in a safe feeding position and was seated in a wheelchair that was reclined at an approximate 115 degree angle. The Personal Care Aide was standing approximately 16 inches above the resident's eye level.

The Personal Care Aide acknowledged that resident was not in a safe feeding position and that the resident should have been upright and she/he should have been seated to assist the resident.

The Assistant Director of Care acknowledged the potential risk and indicated the expectation was that staff were expected to be at the resident's eye level to ensure that

the resident did not aspirate.

Another Personal Care Aide was observed standing to feed Resident # 027 an afternoon snack. The resident was not in a safe feeding position and was sitting reclined in a wheelchair at an approximate 120 angle, in an identified Neighborhood hallway. The Personal Care Aide was standing approximately 12 inches above the eye level of the resident.

The Personal Care Aide acknowledged awareness that the expectation was that he/she should have been seated at eye level to ensure safety of the resident and indicated that the resident was on a modified texture related to risk of choking. The Personal Care Aide also acknowledged that the resident should have been positioned upright at a 90 degree angle and not reclined. The Personal Care Aide also indicated that the resident was being provided with a modified texture snack related to the resident being at risk of choking.

A Neighborhood Coordinator confirmed that the resident was at choking risk.

The Registered Dietitian indicated, in an interview, the expectation was to ensure safe feeding of residents. She indicated that residents should be seated as upright as possible, staff should be using a small spoon to feed, staff should be seated at a table &/or at eye level of the resident and cueing should be provided related to swallowing and readiness for the next bite. [s. 73. (1) 10.]

2. The licensee failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who require assistance when the following was observed:

On May 11, 2015, a staff member was observed standing to feed resident # 018 his/her am snack .
On May 12, 2015, a staff member was observed standing to feed resident # 019 his/her pm snack.
On May 27, 2015, a staff member was observed, in an identified Neighborhood, standing to feed a resident his/her am snack.

In all incidents, residents were observed to be in an unsafe position and at a potential risk for choking.

During interviews the Director of Food Services and Assistant Director of Food Services confirmed their expectations that staff are to ensure that residents are in a safe feeding position when being fed. [s. 73. (1) 10.]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements: 1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review. 2. The system must be ongoing and interdisciplinary. 3. The improvements made to the quality of the accommodation, care, services, programs and

goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis. 4. A record must be maintained by the licensee setting out, i. the matters referred to in paragraph 3, ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and iii. the communications under paragraph 3.

Interviews, observations and record reviews, throughout the RQI, revealed:

a) There was no documented evidence of a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
b) The Long Term Care Homes Licensee Confirmation Checklist for Quality Improvement and Required Programs, signed by the Interim Assistant General Manager, in the initial stages of the Resident Quality Inspection, was not accurately completed and required a revision.
c) There was no monitoring of infection prevention and control practices.
d) There was no analysis of call bell response time records.
e) There was no monitoring and analyzing of maintenance deficiencies.
f) There was no monitoring of safe feeding techniques/positioning of residents despite the home being made aware of this potential risk on May 11, 2015.
g) There was no monitoring to ensure residents' Personal Health Information is kept secure and confidential. [s. 228.]

2. The licensee has failed to ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents were communicated to the Family Council.

An interview with the President of the Family Council, on May 25, 2015, revealed that improvements made through the quality improvement and utilization review system had not been communicated to the Council despite the Council requesting the results of quality improvement initiatives.

A review of the Family Council minutes revealed that there was no documented evidence to support that improvements made through the quality improvement and utilization review system were communicated to the Family Council.

The Long Term Care Homes Licensee Confirmation Checklist for Quality Improvement

and Required Programs, signed by the Interim Assistant General Manager in the initial stages of the Resident Quality Inspection, also indicated that the licensee had not communicated improvements made to the quality of care services, programs, accommodation, and good to the Family Council.

The Interim Assistant General Manager acknowledged that quality improvements made in the home had not been communicated to the Family Council. [s. 228. 3.]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to be afforded privacy in treatment fully respected and promoted.

A Registered Staff member was observed performing a treatment for Resident # 25 in the lounge, of an identified Neighborhood, with six other residents present.

In an interview, the Registered Staff member confirmed that the treatment was done in the lounge and indicated that the resident should have been taken to his/her room to be afforded privacy in treatment.
The Registered Staff member also confirmed that receiving care in the lounge was not documented in the plan of care for the resident.

The Director of Nursing Care acknowledged that it was the home's expectation that treatments should not be done in public areas unless the resident has agreed to that and, if they had, it would be included in the resident's life plan (care plan). She also indicated that the expectation was that staff needed to honor privacy and respect while doing treatments. [s. 3. (1) 8.]

2. The licensee has failed to ensure that the following right of residents is fully respected and promoted: 11. Every resident has the right to, iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

Observations, throughout the RQI, revealed the following:

(a) On May 11, 2015, the Erin chart room door was observed open with no staff in attendance and residents' Personal Health Information (PHI) was accessible.
The RAI/QI Coordinator confirmed the door should be locked when no staff present to ensure residents' PHI is kept confidential.

(b) May 12, 2015, the Nichol chart room door was observed open with no staff in attendance and residents' Personal Health Information (PHI) was accessible.
Two Personal Care Aides confirmed the chart room was open and unattended with no staff in attendance, as well as the expectation that the door be locked when no staff present to ensure residents' PHI is kept confidential.

(c) May 12, 2015, the Nichol chart room door was observed open and unattended, with no staff in attendance. The registered staff member was in the medication room with his/her back to the medication room door and the chart room was not within visual proximity of the registered staff member.
A registered staff member confirmed the chart room door was open and unattended with no staff in attendance, as well as the expectation that the door be locked when no staff members are present, to ensure residents' PHI is kept confidential.

(d) May 12, 2015, the Erin chart room door was observed to be unlocked and unattended, with no staff in attendance, allowing residents' PHI to be accessible.
A RAI/QI Coordinator confirmed the chart room door was unlocked and unattended, allowing residents' PHI to be accessible, as well as the expectation that the door be kept locked when no staff present to ensure residents' PHI is kept confidential.

(e) May 13, 2015, the Eramosa chart room door was observed unlocked and unattended, with no staff in attendance.
A registered staff member confirmed the chart room door was unlocked and unattended, with no staff in attendance, as well as the expectation that resident PHI should be kept confidential and not be accessible.

(f) May 19, 2015, the Erin chart room door was observed to be open and unattended, with no staff in visual proximity, allowing access to residents' PHI.

(g) May 20, 2015, the Mapleton chart room door was observed to be open and unattended, allowing access to residents' PHI.
The registered staff member was administering medications at the dining room entrance, had his/her back to the chart room door and the chart room door was not in visual proximity.

An interview with the Interim Assistant General Manager and Director of Nursing Care confirmed the expectation was the chart room doors are to be locked when no staff members are in attendance, as well as that residents PHI be kept secure and confidential. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure every resident has his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act and privacy in treatment is fully respected and promoted, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents when the following was observed during a tour of the home May 11, 2015:

The door to an identified Neighborhood Servery Kitchen was open and left unattended with chemicals readily accessible to residents.
There were four containers of various chemicals including disinfectant, multi-surface cleaner, cleanser, and detergent.

The unlocked and unattended kitchen servery, with chemical access to residents, was confirmed by a staff member.

During an interview, the Director of Food Services confirmed her expectation is that the home be a safe and secure environment for its residents. [s. 5.]

2. The licensee failed to ensure that the home is a safe and secure environment for its' residents.

Observations, during the initial tour and during the RQI, revealed:

(a) A can of heavy duty oven cleaner was in an unlocked cabinet, in the Country Kitchen on an identified Neighborhood, allowing access to residents.

(b) PUREX liquid laundry detergent was in an unlocked cabinet, in Country Kitchen on an identified Neighbourhood, allowing access to residents.
Directions indicated may irritate eyes. Do not induce vomiting if swallowed.

(c) Nature clean liquid laundry detergent was observed on top of the dryer, near an identified dining room.
Directions indicated may irritate eyes. Do not induce vomiting if swallowed.

(4) On May 11, 2015, the Thermopatch clothing labeler was observed in the hallway, across from an identified dining room. It was on a cart, unattended and was still hot. The inspector brought the machine to the main office. The Scheduling Coordinator confirmed the machine was still hot, unattended and the expectation was it not be left

unattended, as well as it should be returned to its' proper location when no longer in use, as it posed a potential risk to residents.

An interview with the Interim Assistant General Manager and Director of Nursing Care revealed hazardous chemicals are to be secured to ensure inaccessibility to residents, the Thermopatch labeler not be left unattended and the home is to be a safe and secure environment for its' residents. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home was a safe and secure environment for its residents, to be implemented voluntarily.

WN #9: 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. (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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan when the following occurred:

An identified resident was hospitalized with dehydration.

The resident's Nutritional Care plan, at that time, specified that a referral will be made to the Registered Dietitian when the resident's fluid intake is less than 1500 millimetres for five consecutive days.

Record review of the resident's Nutrition and Hydration Flow sheet, for two different time periods, revealed the resident's fluid intake was less than 1500 millimetres/day for five or more consecutive days:

Time Period # 1 - for five consecutive days, the resident's average intake was 669 mls./day
Time period # 2 - for five consecutive days the resident's average fluid intake was 950 mls./day

In an interview the home's Registered Dietitian confirmed that resident #009 had not been referred for fluid intake of less than 1500 mls./day for five consecutive days as per the Plan of Care.

During an interview the Registered Dietitian confirmed her expectation that the care set out in the plan of care is provided to the resident as specified in the plan related to referrals for residents with low fluid intakes. [s. 6. (7)]

2. The Licensee failed to ensure that the resident was reassessed and the plan of care revised when care set out in the plan had not been effective, and that different approaches be considered in the revision of the plan of care when the following occurred:

Record review revealed an identified resident had been experiencing increasing pain rated as seven or eight out of ten on six occasions during a one month time period and required analgesics as needed.

In an interview, the registered staff member confirmed that the resident had ongoing increasing pain level greater than four out of ten and had not been reassessed nor had interventions been put in place, as per the home's Pain Management Policy, of March 2015, to maintain comfort and reduce the resident's pain levels.

During an interview the Assistant Director of Nursing Care confirmed his expectation that residents are reassessed for increasing pain and that the care plan be revised when care set out in the plan has not been effective, and that different approaches be considered in

the revision of the plan of care. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #10: 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 has failed to ensure that a resident-staff communication and response system could be easily accessed and used by all residents at all times.

Resident # 012 was observed sitting, watching television, in his/her reclined bedroom comfortable chair. The call bell was on the other side of the bed attached to the wheelchair and was not within reach of the resident.

A Personal Care Aide confirmed the observation and acknowledged that the call bell should have been within reach of the resident and placed the call bell next to the resident.

The Assistant Director of Care indicated the expectation was that the call bell should have been accessible and within reach of the resident. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident-staff communication and response system could be easily accessed and used by all residents at all times, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of Resident # 015's clinical record, revealed there were six documented entries where the resident expressed pain rated as seven or eight out of ten and required analgesics as needed.
The resident's plan of care stated the resident will have a weekly pain assessment.

Record review with a Registered Staff member revealed there was no documented evidence that weekly pain assessments were completed during a one month time period.

In an interview the Assistant Director of Nursing Care confirmed his expectation that resident's experiencing pain are assessed weekly using a clinically appropriate assessment instrument. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #12: 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 has failed to ensure that a response in writing was provided to Family Council, within 10 days of receiving advice related to concerns or recommendations.

A review of the Family Council minutes for 2015 revealed that concerns to which they requested a response were expressed each month in the minutes.

The Interim Assistant General Manager acknowledged that he had received the minutes, of the February 26, 2015 Family Council meeting, on March 9, 2015.
The concerns/recommendations identified during the meeting included issues with MOHLTC funding, parking, snow removal, sufficient staffing, absence of staff in the neighborhoods during evenings and education/training.

The response from the Interim Assistant General Manager was dated March 10, 2015 but it was not returned to the Family Council Chairperson until March 23, 2015. This was 14 days after receiving the advice from the Council.

The Interim Assistant General Manager acknowledged that he had received the minutes, of the March 26, 2015 Family Council meeting, on April 9, 2015.
The concerns/recommendations identified during the meeting included issues with parking, policies regarding personal care/hygiene, disinfection practices, care of residents, physician coverage, and the satisfaction survey.

The response from the Interim Assistant General Manager was dated April 21, 2015 and returned to the Family Council Chairperson on April 21, 2015 which was 12 days after receiving the advice.

The Interim Assistant General Manager acknowledged that he had not provided a response, in writing to Family Council, within 10 days of receiving advice related to their concerns. [s. 60. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a response in writing was provided to Family Council, within 10 days of receiving advice related to concerns or recommendations, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the Nutrition Care and Hydration Program residents' heights are taken, upon admission and annually as follows:

Record review in two identified Neighborhoods revealed that 38 of 60 residents (63.3 per cent) did not have their heights taken annually, for example:

Resident # 009-last height taken was May 27, 2011
Resident # 020 -last height taken was June 25, 2010
Resident # 021- last height taken was May 22, 2011

In an interview, the Assistant Director of Nursing Care confirmed his expectation that resident's heights are taken upon admission and annually thereafter. [s. 68. (2) (e) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that as part of the Nutrition Care and Hydration Program residents' heights are taken, upon admission and annually, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

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

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, at least once in every year, a survey was taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

There was no documented evidence to support that a satisfaction survey, to measure the satisfaction of families, was conducted in 2014.

An interview with a representative of the Family Council on May 25, 2015, revealed that the Family Council had requested input into the survey to measure family satisfaction and initiated development of the survey in the fall of 2014.

The minutes for the March 26, 2015 Family Council meeting requested that Family Council be provided with a copy of the new Family Member Satisfaction Survey, as requested in January 2015.

The response from the Interim Assistant General Manager to the March meeting was dated April 21, 2015 and stated "The Villages have not yet been provided with the final version of the Satisfaction Survey. As soon as the survey is completed, it will be shared with Family Council".

The Interim Assistant General Manager acknowledged that there was no evidence to support that the satisfaction of families was measured in 2014. [s. 85. (1)]

2. The Licensee failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results as follows:

During an interview with a representative of the Residents' Council revealed that the Licensee had not sought the advice of the Residents' Council in developing and carrying out the Resident Satisfaction Survey.

In an interview, the General Manager confirmed his expectation that the licensee seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

3. The Licensee failed to document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey when the following occurred:

During an interview with a representative of the Residents' Council revealed that the Licensee had not documented or made available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council, regarding the survey.

In an interview the General Manager confirmed he had not shared the results of the survey with Residents Council , however it was his expectation that the licensee document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council. [s. 85. (4) (a)]

4. The licensee has failed to document and make available to the Family Council the results of the satisfaction survey in order to seek the advice of the Council about the

survey.

An interview with a representative of the Family Council revealed that the Family Council had not been provided with the results of the resident satisfaction survey for 2014.

A review of the Family Council minutes revealed that there was no evidence to support that the resident satisfaction survey results had been shared.

The Interim Assistant General Manager indicated, in an interview, that the General Manager shared the results of the satisfaction survey with Family Council, in January 2015.

However, the General Manager confirmed that he had not shared the satisfaction survey results with the Family Council. [s. 85. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, at least once in every year, a survey was taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home and to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results, as well as to document and make available to the Residents' and Family Councils the results of the satisfaction survey in order to seek the advice of the Council about the survey, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use.

1) Topical Creams are stored in linen rooms for trained Personal Care Aides to apply.

In an identified Neighborhood, the linen door was observed open and unattended allowing resident access to topical medication creams including six jars of Clotrimaderm Cream 1%, Emo Cort Cream and Polysporin Antibiotic Cream; Anuzinc Ung 5 mg/gm, Betaderm Lotion – 75 mls X three and six bottles of mouthwash.

A Personal Care Aide confirmed the linen door was unlocked and unattended, as well as the expectation that the topical creams not be accessible to residents.

2) An identified prescription cream was observed on the bedside table for Resident # 012. There was no documented evidence in the physician's orders that the cream may be kept at bedside.

A registered staff member confirmed the cream was at the bedside and removed it, as well as the expectation that prescription creams be locked up when not in use. [s. 130. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

Issued on this 10th day of June, 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) :	MARIAN MACDONALD (137), BONNIE MACDONALD (135), RUTH HILDEBRAND (128)
Inspection No. / No de l'inspection :	2015_217137_0021
Log No. / Registre no:	008689-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 8, 2015
Licensee / Titulaire de permis :	OAKWOOD RETIREMENT COMMUNITIES INC. 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF RIVERSIDE GLEN 60 WOODLAWN ROAD EAST, GUELPH, ON, N1H-8M8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bryce McBain

To OAKWOOD RETIREMENT COMMUNITIES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;

(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and

(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).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, S.O. 2007, c.8, s. 15(2)(c) to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, specifically related to:

a) the damaged/stained lipped plates and plastic beverage glasses are replaced.

b) damaged and paint chipped doors, door frames, walls and base boards, throughout the home, are repaired and painted.
c) the damaged wooden handrails, throughout the home, are repaired.
d) insects are removed from the identified light fixtures, throughout the home.
e) damaged wallpaper, in identified locations, is repaired or replaced.
f) damaged and discloured wall tiles and flooring, in Nichol tub room, are repaired or replaced.
g) the shower curtain and toilet grab bar are repaired, at the wall in Eramosa SPA.
h) the sofa table and coffee tables, in Arthur and Mapleton lounges, are repaired.
i) ensuring the black gouge marks and sticky film build-up on dining room floors in Mapleton and Eramosa are removed/repaired..
j) stained ceiling tiles, near Mapleton Nursing Station, are replaced.
k) the removal of the black mould-like growth in Mapleton shower room.
l) the finish/paint on the metal gate and handrails in front foyer stairwell, as well as bed rails in identified residents' rooms, are repaired.
m) the flooring is repaired in the front entrance, under the mat that is secured to floor with red and yellow duct tape.
n) a preventive maintenance schedule is developed and implemented.
o) there is a process in place to monitor on-going compliance in order that the the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The plan must include what immediate and long-term actions will be undertaken to correct the identified deficiencies, as well as who will be responsible to correct the deficiencies, the dates for completion and monitor on an ongoing basis.

Please submit the plan, in writing, to Marian.C.Mac Donald, Long-Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, ON, N6A 5R2, by email, at Marian.C.Macdonald@ontario.ca by June 19, 2015.

Grounds / Motifs :

1. A written notification and a voluntary plan of correction were previously issued on November 27, 2014, under Log # L-001792-12 and Inspection # 2012_171155_0016 and on April 22, 2014, under Log # L-000426-14 and Inspection # 2014_228171_0004 related to the home, furnishings and equipment not being maintained in a safe condition and in a good state of repair.

The licensee failed to ensure that the home, furnishings and equipment were not maintained in a safe condition and in a good state of repair when the following was observed during a lunch service in an identified dining room:

2/3 (66 per cent) of the lipped plates had finish removed and could no longer be sanitized. One plate noted to have food like debris stuck to the plate surface where the surface had been cut.
7/11 (63 per cent) of the eight ounce plastic beverage glasses were stained brown. Three of the 11 glasses were cracked and could no longer be sanitized properly.

During an interview the Director of Food Services confirmed her expectation that the home's furnishings and equipment were to be kept in a safe condition and in a good state of repair. (135)

2. Observations, during the initial tour and throughout the RQI, revealed identified deficiencies including:
(a) Damaged and paint chipped doors, door frames, walls and baseboards in over 25 resident rooms, as well as in common areas, in all six neighborhood home areas.
(b) Wooden hallway handrails damaged, gouged and splintered, with sharp areas of wood exposed posing a potential risk to residents, throughout all six neighborhood home areas.
(c) Dead insects in hallway and dining room light fixtures in Nichol, Puslinch and Eramosa neighborhood home areas.
(d) Damaged wallpaper in hallways of Nichol, Erin, Puslinch and Mapleton Neighborhood home areas.
(e) Front entrance mat secured to floor with red and yellow duct tape.
(f) Damaged and discolored wall tiles and floor in Nichol SPA tub room.
(g) Shower curtain loose from hooks and toilet grab bar loose at the wall in Eramosa SPA.

(h) Sofa table and coffee tables damaged in Arthur and Mapleton lounges.
(i) Black gouge marks and sticky film build-up on dining room floors in Mapleton and Eramosa.
(j) Stained ceiling tiles near Mapleton nursing station.
(k) Caulking along floor tile at shower head with black mould-like growth in Mapleton shower room.
(l) Finish/paint damaged on metal gate and handrails in front foyer stairwell, as well as bed rails in identified residents' rooms.

A tour was conducted with the Interim Assistant General Manager and the Director of Environmental Services.
Both confirmed the identified deficiencies, as well as the expectation that home, furnishings and equipment be maintained in a safe condition and in a good state of repair.
The Director of Environmental Services also confirmed that the home is working on a preventive maintenance schedule but currently there is no schedule in place.
(137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 18, 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. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must take immediate action to achieve compliance by ensuring:

a) all staff participate in and receive education related to the implementation of the infection prevention and control program, including hand hygiene practices.
b) all residents' personal care items and equipment are kept clean, labeled and stored properly to mitigate infection control risks to residents.
c) there is a process in place to monitor on-going compliance so that all staff participate in the implementation of the program, including assigning responsibility for the monitoring.

Grounds / Motifs :

1. A written notification of non-compliance and a voluntary plan of correction were previously issued on January 30, 2014 under Log 3 L-000104-14 and Inspection # 2014_226192_0003, April 22, 2014 under Log # L-000426-14 and Inspection # 2014_228172_0004 and on October 14, 2014 under Log 3 L-005184-14 and Inspection # 2014_183135_0085 related to not all staff participating in the implementation of the infection prevention and control program.

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

During pm snack service on an identified Neighborhood, a student was observed not to be practicing proper hand hygiene when serving residents Danish with his/her fingers, instead of the tongs provided on the snack cart.

During an interview with the Director of Food Services, it was confirmed her expectation that staff and volunteers participate in the implementation of the

infection prevention and control program, when serving resident snacks.
(135)

2. Observations, throughout the RQI, revealed identified infection prevention and control risks in shared resident rooms/washrooms and SPA tub/shower rooms.

(a) Personal care items, such as toothpaste, toothbrushes, combs, hair brushes, electric razors, bedpans, urinals, urine collection hats, etc., were not labeled and stored properly in twelve (12) identified shared resident washrooms.
(b) SPA tub/shower rooms on Nichol, Erin and Puslinch Neighborhoods contained unlabeled toothpaste, combs, body wash, moisture therapy lotions, used bar soaps, body spray, roll on deodorants, shaving cream, hairspray, shampoo and conditioner and Gold Bond body powder,
(c) Steno chairs heavily soiled at Erin neighborhood nursing station.
(d) Nail clippings were observed in nail clipper drawers in Nichol shower room and Puslinch tub room. The tray for disinfecting nail clippers was rusted and soiled.
(e) A review of the Daily Infection Control Surveillance sheets, during an 18 day period, to be completed by registered staff on each shift, revealed the following:
Mapleton - initials missing for eight night shifts
Eramosa - initials missing for six day shifts, four evening shifts and ten night shifts.
Arthur - initials missing for one day shift and three night shifts.
Erin - initials missing for one day shift and seven evening shifts.
Puslinch - initials missing for five day shifts, five evening shifts and one night shift.
Nichol - no initials missing.

A RAI/QI Coordinator confirmed initials were missing and the expectation was that registered staff complete the Daily Infection Control Surveillance sheets on each shift.

A tour was conducted with the Assistant Director of Nursing Care, the Director of Environmental Services and RAI/QI Coordinator/Infection Control designate. All three confirmed that the identified personal care items were not labeled and/or stored properly, posing a potential infection prevention and control risk to residents, as well as the expectation that all staff participate in the implementation of the infection prevention and control program.

During a medication administration observation, a registered staff member did not utilize hand hygiene practices before or after performing a treatment on an identified resident, as well as between administering medications to other residents.

(137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 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 : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(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
(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).

Order / Ordre :

The home shall prepare, submit and implement a plan to ensure that the staffing plan provides 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.

The plan must include what immediate and long-term actions will be undertaken to ensure there is a process in place to monitor on-going compliance, as well as who will be responsible, specifically related to call bell response time monitoring.

Please submit the plan, in writing, to Marian C. Mac Donald, Long-Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, ON, N6A 5R2, by email, at Marian C. Mac Donald@ontario.ca by June 19, 2015.

Grounds / Motifs :

1. A written notification of non-compliance and a Compliance Order were issued on March 17, 2014 under Log # L-000126-14 and Inspection #

2014_202165_0005, as well as on May 26, 2014 under Log # L-000426-14 and Inspection # 2014_228172_0004 related to the staffing plan, which were previously returned to compliance.

The licensee failed to ensure that the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs.

Interviews and record reviews, of the call bell response records for an identified month, revealed:

1) Resident # 011 shared that sometimes the call bells do not get answered in a timely manner on an identified Neighborhood.
A review of the call bell response records indicated on an identified date, the call bell was activated at 18:41:49 and canceled in 26:36 minutes.

2) Resident # 012 shared there is not enough staff available in the evening. Sometimes residents have had to wait over a half an hour to be put to bed in the evening on an identified Neighborhood.
A review of the call bell response records indicated on an identified date, the call bell was activated at 20:15:12 and canceled in 26:55 minutes.

3) Resident # 031 shared having to wait a long time to go to bed as they start at the other hallway first and I usually wait at least a half hour or longer on an identified Neighborhood.
A review of the call bell response records indicated on one identified date, the call bell was activated at 19:01:08 and canceled in 27:59 minutes and on another identified date, the call bell was activated at 18:08:50 and canceled in 28.21 minutes.

4) Resident # 030 shared having to consistently wait for a half hour or longer for staff to respond to the call bell.
A review of the call bell response records for an identified Neighborhood indicated there were fifty-six incidents where Resident # 030 waited over twenty-minutes for a response to the call bell, including nine incidents where the response time ranged from 1 hour + 1:06 minutes to 1 hour + 34.31 minutes.

5) A review of the call bell response records for one identified Neighborhood revealed there were 125 documented entries where the call bell response time was over twenty minutes and on another identified Neighborhood there were 67

documented entries where the call bell response time was over 20 minutes.

6) A concern was raised at the Residents' Council Meeting on October 30, 2014, related to response time for bells. Management was asked to check how long bell response time was on Erin, Puslinch and Arthur during 3-11 shift. The response from the Leadership team was "a new policy has been initiated and appropriate access given to the Neighborhood Coordinators to check call bell response times on a weekly basis".

7) A review of the staffing plan evaluation, dated February 5, 2015, revealed:
A complete review of the staffing levels at Riverside Glen related to care levels has been undertaken over the past month. In particular, the review has been cross referenced with the number of complaints received by residents/families relating to answering of call bells and the provision of a pleasurable dining experience given the amount of assistance required by our frail population.

8) A proposed call bell response policy was developed on November 20, 2014, to audit and monitor call bell response time.
The Interim Assistant General Manager and two registered staff members confirmed the policy has not been implemented and the expectation is that call bell response times be audited and monitored, as well as call bells responded to in a timely manner.

(137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 17, 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. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must take immediate action to achieve compliance with O. Reg. 79/10, s.8(1)(b) to ensure the policies implemented in the home are complied with, specifically related to:

a) ensuring residents are weighed and weights are documented in Gold Care on admission, re-admission, monthly and as deemed necessary, as well as re-weighed when a discrepancy or weight change has been identified, in order for the nutritional status of residents be accurately assessed.
b) ensuring a process is in place to monitor on-going compliance related to weight monitoring, including assigning responsibility for the monitoring.

Grounds / Motifs :

1. A written notification of non-compliance and a voluntary plan of correction were previously issued on April 14, 2015, under Log # 001518-15 and Inspection # 2015_226192_0018, as well as on April 14, 2014, under Log # L-000405-14 and Inspection # 2014_226192_0012, related to the home's weight policy not being complied with.

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

The home's policy for Weight and Height Monitoring reviewed January, 2014 states the following:

2. All Residents will be weighed on admission, re-admission, monthly and as deemed necessary. PCA is responsible for completing the Resident's weight by the 7th of each month.

Record review revealed that residents' weights were not taken monthly as follows:

In an identified Neighborhood, 10 of 32 (31.25 per cent) residents did not have their weight taken in February, 2015.
In another identified Neighborhood, eight of 32 (25 percent) residents did not have their weight taken in April 2015.

The home's policy for Weight and Height Monitoring January, 2014 also states:

3. PCA Weight Responsibilities- the weight will be recorded on the Monthly Weight Record form found in Gold Care under the demographic report for monthly vital sign weight batch form.

Record review revealed residents weights were not recorded on the Monthly Weight Record form found in Gold Care as follows:

In an identified Neighborhood, 27 or 90 per cent of the residents did not have their weights recorded in Gold Care in February, 2015.
In another identified Neighborhood, 23 or 71.8 per cent of the residents did not have their weights recorded in Gold Care in April, 2015

In an interview the home's Registered Dietitian confirmed that residents' weights are not always available monthly, to assess residents nutritional status.

During an interview the Assistant Director of Nursing Care confirmed his expectation that the home's Weight Monitoring policy is complied with ensuring residents weights are taken and documented monthly. (135)

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must take immediate action to achieve compliance by:

a) ensuring proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance.
b) ensuring all direct care staff, volunteers and students receive education related to proper techniques used to assist residents with eating, including safe positioning of residents who require assistance.
c) ensuring there is a process in place to monitor on-going compliance in order that proper feeding techniques are used to assist residents with eating, including safe positioning of residents who require assistance.

Grounds / Motifs :

1. A written notification of non-compliance and a voluntary plan of correction were previously issued on October 19, 2012 under log # L-001402-12 and Inspection # 2012_183135_0007.

The Licensee failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

On May 11, 2015, a staff member was observed standing to feed resident # 018 his/her am snack .
On May 12, 2015, a staff member was observed standing to feed resident # 019 his/her pm snack.
On May 27, 2015, a staff member was observed standing to feed a resident his/her am snack, in an identified Neighborhood,

In all incidents, residents were observed to be in an unsafe position and at a potential risk for choking.

During interviews the Director of Food Services and Assistant Director of Food Services confirmed their expectations that staff were to ensure that residents were in a safe feeding position when being fed.
(135)

2. A Personal Care Aide was observed standing to assist Resident # 026, with drinking a beverage, at a lunch meal in an identified Neighborhood. The resident was not in a safe feeding position and was seated in a wheelchair that was reclined at an approximate 115 degree angle. The Personal Care Aide was

standing approximately 16 inches above the resident's eye level.

The Personal Care Aide acknowledged that resident was not in a safe feeding position and that the resident should have been upright and she/he should have been seated to assist the resident.

The Assistant Director of Care acknowledged the potential risk and indicated the expectation was that staff were expected to be at the resident's eye level to ensure that the resident did not aspirate.

Another Personal Care Aide was observed standing to feed Resident # 027 an afternoon snack, at 1550 hours.. The resident was not in a safe feeding position and was sitting reclined in a wheelchair at an approximate 120 angle, in an identified Neighborhood hallway. The Personal Care Aide was standing approximately 12 inches above the eye level of the resident.

The Personal Care Aide acknowledged awareness that the expectation was that he/she should have been seated at eye level to ensure safety of the resident and indicated that the resident was on a modified texture related to risk of choking. The Personal Care Aide also acknowledged that the resident should have been positioned upright at a 90 degree angle and not reclined. The Personal Care Aide also indicated that the resident was being provided with a modified texture snack related to the resident being at risk of choking.

a Neighborhood Coordinator confirmed that the resident was at choking risk.

The Registered Dietitian indicated, in an interview, the expectation was to ensure safe feeding of residents. She indicated that residents should be seated as upright as possible, staff should be using a small spoon to feed, staff should be seated at a table and/or at eye level of the resident and cueing should be provided related to swallowing and readiness for the next bite. (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 17, 2015

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 228. Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:

1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,

i. the matters referred to in paragraph 3,

ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and

iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. reg. 79/10, s.228 to ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1) There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2) The system must be ongoing and interdisciplinary.
3) The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.

The plan must include what immediate and long-term actions will be undertaken to correct the identified concerns/deficiencies and identify who will be responsible for ensuring the overall quality improvement and utilization review system is fully implemented.

Please submit the plan, in writing, to Marian C. Mac Donald, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, Ontario, N6B 1R8, by email, at Marian.C.Macdonald@ontario.ca by June 19, 2015.

Grounds / Motifs :

1. Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements: 1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review. 2. The system must be ongoing and interdisciplinary. 3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis. 4. A record must be maintained by the licensee setting out, i. the matters referred to in paragraph 3, ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and iii. the communications under paragraph 3.

Interviews, observations and record reviews, throughout the RQI, revealed:

a) There was no documented evidence of a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
b) The Long Term Care Homes Licensee Confirmation Checklist for Quality Improvement and Required Programs, signed by the Interim Assistant General Manager, in the initial stages of the Resident Quality Inspection, was not accurately completed and required a revision.
c) There was no monitoring of infection prevention and control practices.
d) There was no analysis of call bell response time records.
e) There was no monitoring and analyzing of maintenance deficiencies.
f) There was no monitoring of safe feeding techniques/positioning of residents despite the home being made aware of this potential risk on May 11, 2015.
g) There was no monitoring to ensure residents' Personal Health Information was kept secure and confidential. (137)

2. The licensee has failed to ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents were communicated to the Family Council.

An interview with the President of the Family Council, on May 25, 2015, revealed that improvements made through the quality improvement and utilization review system had not been communicated to the Council despite the Council requesting the results of quality improvement initiatives.

A review of the Family Council minutes revealed that there is no documented evidence to support that improvements made through the quality improvement and utilization review system were communicated to the Family Council.

The Long Term Care Homes Licensee Confirmation Checklist for Quality Improvement and Required Programs, signed by the Interim Assistant General Manager, in the initial stages of the Resident Quality Inspection, also indicated that the licensee had not communicated improvements made to the quality of care services, programs, accommodation, and good to the Family Council.

The Interim Assistant General Manager acknowledged that quality improvements made in the home had not been communicated to the Family Council.

(128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 18, 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 8th day of June, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MARIAN MACDONALD

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