Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 15, 2016	2016_448155_0008	013963-16	Follow up

Licensee/Titulaire de permis

Schlegel Villages 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

SHARON PERRY (155), AMIE GIBBS-WARD (630), DEBORA SAVILLE (192), MARIAN MACDONALD (137)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): May 10, 11, 12 and 13, 2016.

This is a follow up to inspection 2016_448155_0002 including the following orders:
CO #002 regarding development and implementation of a continence care and bowel management program;
CO #003 regarding staffing plan that provides for a staffing mix that is consistent with resident's assessed care and safety needs and includes a back plan for nursing and personal care that addresses situations when staff cannot come to work;
CO #004 regarding proper techniques to assist residents with eating, including safe positioning of residents who require assistance;
CO #005 regarding monitoring of all residents during meals;
CO #006 regarding monitoring of symptoms indicating the presence of infection; and
CO#007 regarding residents being reassessed and the plan of care reviewed and revised.

During the course of the inspection, the inspector(s) spoke with Assistant General Manager, Director of Nursing Care, Vice President Operations, Support Office-Nurse Consultants, Food Services Manager, Assistant Director of Nursing Care, Scheduling Coordinator, Administrative Assistant, Registered Dietitian, RAI/QI Registered Practical Nurses, Registered Practical Nurses, Neighbourhood Coordinator, Food Services Workers, Personal Care Aides, Resident Council representative, residents and families.

The inspector(s) also toured the home; observed meal and snack service; reviewed relevant clinical records, reviewed policies and procedures, meeting minutes, schedules; observed the provision of resident care, resident-staff interactions and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Infection Prevention and Control
Medication
Snack Observation
Sufficient Staffing

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #007	2016_448155_0002	192
O.Reg 79/10 s. 73. (1)	CO #005	2016_448155_0002	630

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the continence care and bowel management program was implemented in the home, as required under section 48 of this Regulation.

On March 17, 2016, inspection number 2016_448155_0002, CO #002, the licensee was ordered to take action to ensure that the home has a written description of the continence care and bowel management program, that includes but is not limited to, goals and objectives, relevant protocols, methods to reduce risk, methods to monitor outcomes, and protocols for referral of residents to specialized resources where required. The licensee was also to ensure that the continence care and bowel management program was implemented in the home as required under section 48 of the Regulation.

While the home did develop a continence care and bowel management program, the program had not been fully implemented in the home, as required under section 48 of this Regulation, as confirmed by Assistant General Manager # 100, Director of Nursing

Care # 101, Nurse Consultant # 114 and Registered Practical Nurse – Continence Lead # 136.

The written description of the program included a description of the interdisciplinary team to include, but not be limited to: Director of Nursing Care, Assistant Director of Nursing Care, RAI/QI Registered Practical Nurse, Personal Expressions Resource Team Lead, Personal Care Aides (minimum 2), Registered Practical Nurse (minimum 2), Registered Nurse (minimum 2), Assistant Director Food Services, Neighbourhood Coordinators, Registered Dietitian, Medical Director, Assistant General Manager and Infection Control Lead. It also included that upon admission a detailed three day Voiding and Bowel Elimination record will be completed to determine a detailed record of all continent and incontinent episodes.

The Assistant General Manager # 100, Director of Nursing Care # 101, Nurse Consultant # 114 and Registered Practical Nurse – Continence Lead # 136 all agreed that an integral component of the program was to establish a full complement of members on the team and the completion of the three day voiding records.

The continence team held two meetings. The first meeting was attended by the Director of Nursing Care, Registered Practical Nurse – Continence Lead and two Resident Assessment Instrument/Quality Improvement (RAI/QI) staff.
The second meeting was attended by the Director of Nursing Care, Registered Practical Nurse – Continence Lead and a Nurse Consultant – Support Office.

The team had identified a general trend of unsatisfactory completeness of three day Voiding and Elimination Record.
Registered Practical Nurse - Continence Lead # 136 and Registered Practical Nurse # 130 confirmed the three day voiding record was to be completed on all new admissions but had not been done. [s. 30. (1) 1.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with 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. The licensee failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

On March 17, 2016, inspection number 2016_448155_0002, as part of CO #003 and Director's referral, the home was ordered to prepare, submit and implement a plan to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and included a back up plan for nursing and personal care staffing that addressed situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work.

The home's action plan indicated the following:
-that they would review all master lines in the village and determine appropriate staffing patterns to meet assessed resident needs;
-ensure that all positions have permanent team members in place;
-review and assess call-bell reports weekly;
-highlight call bells that exceeded 10 minutes; and
-call bell monitoring to be reviewed monthly to review staffing needs.

Resident interviews and call bell response times revealed:

A) Resident #066 shared that there was not enough staff as they have waited over an hour at times. They shared that staff come in and shut off the bell after two or three minutes and say they are going to get help but don't come back for long periods. Resident #066 stated that the wait is the longest in early morning.

Review of the call bell response records indicated that on six occasions the time, between when resident #066 activated the call bell and when it was cancelled, exceeded 10 minutes. On one occasion the call bell was activated for 20:53 minutes and on another occasion the call bell was activated for 21:37 minutes.

B) Resident #006 shared that there was not enough staff. Resident #006 shared that they have had to wait and have waited 10 to 20 minutes and even longer on several occasions. They expressed that staff come in, turn off the bell and leave. It takes a while for anyone to come back. The longest wait was in the morning. Resident #006 shared that they were late for breakfast as had to wait for staff.

Inspector #137 spoke with Neighbourhood Coordinator # 007 regarding resident #006 not being in the dining room for breakfast. Neighbourhood Coordinator #007 shared that they were monitoring care on the neighbourhood and that it was not possible as they saw resident #006 in the dining room. Inspector # 137 asked Neighbourhood Coordinator #007 to provide the call bell response record.

A review of the call bell response record, indicated that resident #006 activated the call bell at 0841 hours and it was activated for 14:56 minutes. After review of the call bell response record, Neighbourhood Coordinator #006 shared that resident #006 was late for breakfast. Resident # 006 shared they did go for breakfast but was late getting to the dining room.

Review of the call bell response records for an identified period of time, indicated that on ten occasions the time, between when resident #006 activated the call bell and when it was cancelled, exceeded 10 minutes. On one occasion the call bell was activated for 18:43 minutes.

C) Resident #068 shared that there was not enough staff and has had to wait like everyone else. They expressed that they have waited many times well over ten minutes.

Review of the call bell response records for an identified period of time, indicated on six occasions the time, between when resident #068 activated the call bell and when it was cancelled, exceeded 10 minutes. On one occasion, the call bell was activated for 21:05 minutes, on another occasions the bell was activated for 22:08 minutes and for 29:32 minutes.

D) Resident #069 shared that there was not enough staff and has had to wait to for assistance.

Review of the call bell response records for an identified period indicated on two occasions the time, between when resident #069 activated the call bell and when it was cancelled, exceeded 10 minutes.

E) Resident #020 shared that there was not enough staff. They shared that they needed staff to help them. They stated that they feel that they wait 15 to 20 minutes when they call for help.

Review of the call bell response records for an identified period of time indicated on six occasions the time, between when resident #020 activated the call bell and when it was cancelled, exceeded 10 minutes. On one occasion the bell was activated for 21:38 minutes.

F) Resident #072 shared that there was not enough staff and that they have to wait 10 to 15 minutes to get help. Resident #072 shared that waiting for help happens before and after meals.

Review of the call bell response records for an identified period of time indicated on 13 occasions the time, between when resident #072 activated the call bell and when it was cancelled, exceeded 10 minutes. On one occasion the bell was activated for 29:23 minutes.

G) Resident #016 shared that there was not enough staff and they had to wait.

Review of the call bell response records for an identified period indicated on seven occasions the time, between when resident #016 activated the call bell and when it was cancelled, exceeded 10 minutes.

2. Observations during meal service on an identified date, in a dining room found multiple residents who required assistance with eating were served meals prior to having someone available to provide the assistance.

A) Observations of resident #026, during the meal found he/she was unable to feed themself without assistance from staff. This resident was served the meal and at that time did not pick up their utensils or start eating. After twenty-two minutes, resident #026 received a verbal cue from PCA #137 and started to eat. No other assistance was offered to resident #026 and they stopped eating their meal 5 minutes later. Resident #026 was observed to eat less than 25 per cent of their meal.

B) Observations of resident #027, during the meal found resident #027 was served their meal and started to feed themself but then left the table shortly after indicating they had to use the washroom. Resident #027 returned, after sixteen minutes, to their meal which was still on the table but did not receive assistance or start eating. Seventeen minutes later, PCA #137 sat down with resident #027 and attempted to assist resident #027, but resident was asleep. Seven minutes later, the main entrée for resident #027 was cleared and they were observed to have eaten less than 25 per cent of the meal. Dessert was served but resident #027 did not feed themself this item and no assistance was provided.

Clinical record review for resident #027 showed the plan of care for eating included the following interventions: "he/she may require feeding" and "may need one person extensive assistance".

C) Observations of residents #028 and #029 during the meal found they were each served a meal at an identified time. There were no staff at the table to provide assistance and they were both unable to start feeding themselves. Twenty-seven minutes later, a PCA sat at the table and provided total assistance with the meal. During an interview it was reported that both residents required total assistance with eating.

3. Observations of the nourishment cart on an identified date, in an Neighbourhood found the fluids and labelled snacks were being served without the assistance of staff. There was no staff observed for twenty minutes while snacks were being delivered. The home's policy titled "Nourishments", states that the nursing team will serve snacks and that snacks will be served at 1000-1100 hours. At 1100 hours, Support Office-Nurse Consultant #114 came to assist. At 1105 hours, the Food Services Manager #109 also came to assist with the morning nourishment cart. Resident #054 was listed to get a

specific juice but there was none available so resident #054 did not get any nourishment offered.

Resident #052 was poured 60 ml of juice and was listed on the "Snack Delivery Report" to receive "125 ml Pear Drink". The drink was placed on the table just inside the door of the room without being offered to the resident.
Resident #069 was poured 80 ml of juice and was listed on the "Snack Delivery Report" to receive "125 ml Pear Drink". The drink was placed on the table just inside the door of the room without being offered to the resident.
Review of the "Snack Delivery Report" identified that a labelled snack that had been sent for resident #055 was served to resident #056 instead.

4. A review of the Resident Council meeting minutes, for and identified date, revealed concerns related to staffing shortages on two Neighbourhoods and call bells being turned off, with offer of returning with help, but no one returns for a long time.

Resident #076, shared that there was still a problem with not having enough staff. They shared that one Neighbourhood on evenings was the worst. Resident #076 shared that they go to each Neighbourhood, at least every ten days to observe. They noted that on evenings that one hour after staff start work, staff are going on coffee break. Resident #076 shared, before supper is the time when residents need help to go to the washroom but they have to wait because there is not enough staff around to help. Resident #076 said that they have shared this information with the General Manager but feels that no one listens.

5. Review of the call bell response records for an identified period of time was done for three neighbourhoods. Review revealed the following:
A) One identified neighbourhood—52 call bells activated for greater than 10 minutes. Twenty occurred during day shift (38%), thirty-one on evening shift (60%) and one on night shift (2%).
B) One identified neighbourhood—56 call bells activated for greater than 10 minutes. Eleven occurred during day shift (20%) and forty-five (80%) occurred during evening shift.
C) One identified neighbourhood----37 call bells activated for greater than 10 minutes. Twenty-two occurred during day shift (59%), eleven on evening shift (30%) and four on night shift (11%).

Interview with the Assistant General Manager #100 and Neighbourhood Coordinator

#107 revealed that they were meeting weekly to review all call bells greater than 10 minutes and the maximum wait times on each Neighbourhood for the week. They confirmed that the call bell records revealed that residents are ringing and waiting greater than 10 minutes despite all Personal Care Attendant (PCA) shifts being filled for the identified period on these Neighbourhoods.

Interview with the Assistant General Manager #100 and Neighbourhood Coordinator #107 revealed that there had been twenty-three vacant Personal Care Aides (PCA) positions and that they have hired twenty-nine Personal Care Aides. Assistant General Manager #100 shared that all the master lines for Personal Care Aides had been filled but could not demonstrate how the residents were assessed to determine that the staffing patterns meet the assessed resident needs. The Assistant General Manager #100 confirmed that no additional Personal Care Aide hours have been added to the staffing plan. [s. 31. (3)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: 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).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

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

On March 17, 2016, inspection number 2016_448155_0002, CO #004 and Director's referral, the licensee was ordered to take action to achieve compliance with O.Reg 79/10, s.73.(1) 10. by ensuring staff use proper techniques to assist residents with eating, including safe positioning.

On an identified date, Personal Care Aide # 120 was observed standing while feeding thickened juice to resident # 083, in a neighbourhood lounge area.
The resident was seated and the Personal Care Aide was standing approximately 16 inches above the resident's eye level.

The Personal Care Aide acknowledged that he/she should be seated to assist the resident.

The Director of Nursing Care # 101 (DNC) acknowledged the potential risk and indicated the expectation was that team members were expected to be at the resident's eye level, when assisting residents with eating, to ensure that the resident did not aspirate.
The DNC also shared that all front line staff, including PCA #120, and staff from other departments had received education related to proper techniques to assist residents with eating, including safe positioning of residents who require assistance and the observed practice was not acceptable. [s. 73. (1) 10.]

2. Observations of resident #051 on an identified date, during the meal in the dining room found resident #051 was leaning to the right and leaning forward in the wheelchair while being assisted with food and fluids. There was no table tray in place or other observed positioning devices.

Observations of resident #051 on another identified date, during another meal found resident #051 was leaning to the right with the side of their body leaning on the arm rest and right arm unsupported and dangling down beside the wheel. The wheel chair was observed to be tilted back about 30 degrees from upright position. There was no table tray in place or other observed positioning devices. Personal Care Aide (PCA) #117 was sitting on the left of the resident providing total assistance and was observed to say to resident #051 "can you sit up this way as I can't see your mouth". Resident #051 was

observed to cough intermittently during the meal. Twenty minutes after the meal had started, PCA #117 was observed to reposition resident #051 to a more upright position using a blanket.

Interview with RPN #146 acknowledged that resident #051 was not positioned properly for eating.
Interview with RPN #136 identified that the Occupational Therapist had left a note for the physician recommending a device for improved positioning of resident #051. RPN #136 confirmed that after twenty-one days, this recommendation had not been signed off or checked as completed by the physician and the device had not been ordered.

Clinical record review found that on two identified dates resident #051 was seen by the Occupational Therapist who made recommendations regarding device to improve positioning.

Interview with Assistant Director of Nursing Care #131, reported that 100 per cent of staff had completed the mandatory training on feeding assistance which included education regarding safe positioning at meals. Food Services Manager #109 reported that the training for feeding assistance was completed on-line by staff and provided a copy of the education material. Review of the "Supportive Dining: Team Member Training" slide number 1.8 titled "Resident Positioning" stated "we need to strive to place our residents in positions which ensure they sit upright, in neutral". [s. 73. (1) 10.]

3. The licensee has failed to ensure that residents who required assistance with eating or drinking were only served a meal when someone was available to provide the assistance.

Observations during the meal service on an identified date, in an identified Neighbourhood dining room found multiple residents who required assistance with eating were served meals prior to having someone available to provide the assistance.

a) Observations of resident #026 during this meal found he/she was unable to feed themself without assistance from staff. This resident was served the meal and at that time did not pick up their utensils or start eating. After twenty-two minutes, resident #026 received a verbal cue from PCA #137 but no other assistance during the meal. Resident #026 stopped eating their meal after five minutes and overall was observed to eat less than 25 per cent of their meal. During an interview with PCA #137, it was reported that the reason resident #026 did not receive more assistance with this meal was because

they thought resident #026 wasn't hungry as PCA #137 reported the resident tended to eat when they were hungry.

Observations of resident #026 on another identified dated, during another meal found resident #026 was receiving extensive assistance from PCA #147. During an interview with PCA #147 it was reported that resident #026 required extensive assistance with eating as they had difficulties feeding themself.

b) Observations of resident #027, during the meal found resident #027 was served their meal and started to feed themself but then left the table shortly after indicating they had to use the washroom. After sixteen minutes, resident #027 returned to their meal which was still on the table but did not receive assistance or start eating. Seventeen minutes later, PCA #137 sat down with resident #027 and attempted to assist resident #027, but resident was asleep. Seven minutes later, the main entrée for resident #027 was cleared and they were observed to have eaten less than 25 per cent of the meal. Dessert was served but resident #027 did not feed themself this item and no assistance was provided.

During an interview with PCA #137 it was reported that resident #027 did need assistance with their meal as they were tired and had received extra pain medication earlier in the day.

Clinical record review for resident #027 showed the plan of care for eating included the following interventions: "sitting at an assisted table at meal times as he/she may require feeding" and "may need one person extensive assistance to get me started as I may not be focused at meals".

c) Observations of residents #028 and #029 during the meal on an identified date, found they were sitting together alone at a table and were each served a meal. There were no staff at the table to provide assistance and they were both unable to start feeding themselves. Twenty-seven minutes later, a PCA sat at the table and provided total assistance with the meal. During an interview with PCA #137 it was reported that both residents required total assistance with eating.

Clinical record review for resident #028 showed the plan of care for eating included that they required total assistance to eat his/her meal.
Clinical record review for resident #029 showed the plan of care for eating included that they required extensive to total assistance of one care team member to eat and drink.

Interview with Assistant General Manager #100 and Director of Nursing Care #101 acknowledged it was the expectation in the home that residents would not be served a meal until staff were available to provide the eating assistance required. [s. 73. (2) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #4: 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. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

On March 17, 2016, inspection number 2016_448155_0002, CO #006, the licensee was ordered that they must take action to achieve compliance with O.Reg.79/10, s.229.(5)(a) to ensure that on every shift symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices.

Interview with Assistant Directors Nursing Care (ADNC) #131 and #132 identified that it was the expectation that registered staff on each neighbourhood, complete the Daily Infection Control Surveillance record on each shift, listing the first symptoms of infection identified in any resident on the neighbourhood. Auditing for the completion of the Daily Infection Control Surveillance record was being completed daily or every other day by the

Assistant Directors of Care to ensure compliance. Information from the 24 hour shift report completed by the Registered Nurse was reviewed daily to ensure any resident with identified symptoms of infection were included on the Surveillance Record.

Daily Infection Control Surveillance records for March and April 2016, were observed. Daily Infection Control Surveillance records for May 2016, were reviewed for each neighbourhood.

Review of an identified Neighbourhood, Daily Infection Control Surveillance record identified that resident #006 was added to the Surveillance Record. Review of progress notes identified a registered staff member documented that resident #006 exhibited signs and symptoms of infection and a note was left for the physician. Interview with ADNC #132 confirmed that it would be the expectation that at the first symptom of infection, a resident was to be added to the Daily Infection Control Surveillance record and that resident #006 should have been added two days earlier.

Review of an identified Neighbourhood, Daily Infection Control Surveillance record identified that resident #007 was added to the Surveillance Record. Resident #007 was started on an antibiotic. Interview with ADNC #132 confirmed that resident #007 should have been added to the Daily Infection Control Surveillance record three days earlier.

A random sampling of records were reviewed from residents not identified on the Daily Infection Control Surveillance records for three identified Neighbourhoods.
Record review identified that resident #012 presented with signs and symptoms of infection on an identified date and four days later was placed on antibiotics. Interview with ADNC #132 confirmed that resident #012 was not included on the Daily Infection Control Surveillance record for the identified Neighbourhood and that the resident should have been included.

Interview with ADNC #132 identified that if registered staff did not communicate to the Registered Nurse that a resident had symptoms of infection, it would not be included in the 24 hour report and there would be no way for the ADNC to confirm that the Daily Infection Control Surveillance record was complete.

The licensee failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [s. 229. (5) (a)]

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. 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 has failed to ensure that the nutrition and hydration care program included the implementation of policies and procedures relating to nutrition care and dietary services and hydration for nourishments.

Observations of the nourishment cart on an identified date, in an Neighbourhood found the fluids and labelled snacks were being served without the assistance of staff. There was no staff observed for twenty minutes while snacks were being delivered.

During an interview with Nurse Consultant #114 and Food Services Manager #109, it was reported that this volunteer did the snack regularly on this neighbourhood and other

neighbourhoods in the home. The Nurse Consultant #114 identified that staff work with the volunteer to deliver the cart but acknowledged that on some occasions the volunteer started the cart without a staff person.

Review of the Food Services Nutritional Care policy titled "Nourishments" dated May 2014 stated the " Nursing Team will serve snacks with consideration to the information on the Nourishment List".

During an interview with Assistant General Manager (AGM) #100 and Director of Nursing Care #101, they indicated that this identified volunteer should not have been doing the morning snack without staff assistance. The AGM further acknowledged that the process for nourishment service in the home now included anyone who was available to assist with the nourishment carts at snacks including the management team. [s. 68. (2) (a)]

2. The licensee has failed to ensure that the nutrition and hydration care program included the implementation of interventions to mitigate and manage risks related to nutrition care, dietary services and hydration.

a) Observations during the lunch meal service, in the dining room found RPN #113 was making resident #023 thickened milk and thickened coffee at the table. The thickened fluids were observed to be close to pudding thickness and appeared lumpy. RPN #113 was observed not to be following the recipe on the "Thicken-Up Clear" container. Resident #023 was observed to be coughing on the fluids after they were given to them by RPN #113.

Interview with the Food Service Manager (FSM) #109 confirmed that the thickened fluids for resident #023 had not been prepared correctly. FSM #109 acknowledged that RPN #113 was not following the correct process for thickening the items for resident #023. FSM #109 was observed to remove the first milk prepared for resident #023 and prepared a new portion. FSM #109 said it was the practice in the home for the staff to prepare the thickened fluids at the table using the recipe on the container or in the nourishment binder. FSM #109 confirmed there was no recipe for staff to refer to in the nourishment binder.

Review of the clinical record for resident #023 found:
-Registered Dietitian (RD) #142 assessment note, that stated resident was having difficulties swallowing" and that fluids were to be nectar thick.
- Plan of care identified that resident was a high nutritional risk and nectar thickened

fluids were to be provided.

b) Observations during the meal service, in the dining room found Personal Care Aide (PCA) #111 was making resident #021 thickened water at the beverage cart. The thickened fluid was observed to be close to honey thickness. PCA #111 was observed not to be following the recipe on the "Thicken-Up Clear" container.

Interview with PCA #111 identified that they had not followed the recipe on the "Thicken-Up Clear" container as they thought the recipe did not seem correct for this fluid. The PCA reported that they thought resident #021 required fluids that were between nectar and pudding thickness and that sometimes this resident needed the fluids thinner and other times thicker. PCA #111 said the texture for this resident's fluids were listed in the servery diet list and the plan of care but they did not need to look at these as they knew the residents.

Interview with Food Services Worker #112 identified that the order listed for resident #021 in the servery diet list indicated "nectar thickness".

Review of the clinical record for resident #023 found:
-RD #142 assessment note that stated resident was changed to a high nutritional risk and placed on a regular fluid trial
- Plan of care identified indicators of high nutritional risk and provide nectar fluids.

During an interview with Neighbourhood Coordinator #110, it was reported that it was the expectation in the home that the thickened fluids prepared by staff and given to residents in the dining room would match the recipe and the plan of care.

c) Review of the Food Services Nutritional Care policy titled "Thickened Fluids" dated June 2010 stated "all hot and cold beverages and soups will be thickened prior to serving at meals as indicated on the resident care plan" and "standardized recipes will be available and followed for thickened fluids".

During an interview with FSM #109, it was reported that they were unsure exactly when the training was provided to the front line nursing staff on how to prepare thickened fluids but thought it was done over two years ago. FSM #109 was unable to produce a record of which staff had attended the in-services on how to prepare thickened fluids. They acknowledged there were concerns with the current process in the home for preparation of thickened fluids and as a result they were planning to switch to purchasing pre-

thickened fluids instead of having the staff prepare them at the time of service.

During an interview with the Registered Dietitian (RD) #147, it was acknowledged that serving fluids that were not the correct texture to residents with dysphagia was considered to be a risk issue. The RD identified that they had noticed staff in the home were not preparing the thickened fluids based on the recipe and had brought this to the attention of the FSM through an email earlier in the week. RD #147 indicated it was the expectation in the home that residents with swallowing difficulties would be served the correct texture fluids to help mitigate risks. [s. 68. (2) (c)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the nutrition and hydration care programs include the implementation of policies and procedures relating to nutrition care and dietary services and hydration, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

On May 10, 2016, it was identified that the tub room door on an identified Neighbourhood, which was to be locked when not in use, was readily pushed open and would be accessible to residents. Inspector #192 was able to push open the tub room door without using the keypad available on the door. Once inside the room, there were cleaning solutions accessible to anyone entering the room.

On a table beside the tub (which would be accessible from a wheelchair) was a spray bottle containing Everyday Disinfectant. The label on the spray bottle indicated the product required the use of personal protective equipment and to refer to the Material Safety Data Sheet (MSDS).

Interview with Personal Care Aide (PCA) #128 confirmed that Everyday Disinfectant and tub cleaner were accessible in the room. Everyday Disinfectant was removed from the tub room by PCA #128.

During observation with PCA #128 the door to the tub room was observed to remain open three of four times tried. When pulled closed the door would lock, however the closer was not closing the door and securing the lock.

Interview with PCA #124 confirmed that the tub room door was not closing and locking, that the concern had been reported to maintenance and had not been repaired.

Ambulatory residents were observed wandering the identified Neighbourhood.

The licensee failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times. [s. 91.]

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 hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #7: 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 were stored, were kept locked at all times, when not in use.

On an identified date, two baskets of topical medications were observed on top of a care cart, in the hallway of an identified Neighbourhood. The care cart was unattended, allowing resident access to topical medications.

Registered Practical Nurse # 138 and Personal Care Aide # 139 confirmed the topical medications were unattended, as well as the expectation that the topical medications not be accessible to residents and were to be stored in a secure area when not being used. [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 ensue that all areas where drugs are stored shall be kept locked at all times, when not it use, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care for positioning for eating, so that the different aspects of care were integrated and consistent with and complemented each other.

Observations during the meal service, in the dining room found resident #025 was tilted back about 30 degrees from upright in a tilt wheelchair. PCA #126 reported that tilting resident #025 back during meals was part of resident #025 plan of care.

Interview with resident #025 and their partner, identified that this resident preferred to be tilted back in their wheelchair when eating as they found it more comfortable and easier to swallow when in this position.

Interview with RD #142, identified that they had not received a referral regarding positioning for resident #025 at meals and that they were not aware that resident #025 was being tilted at meals. RD #142 reported that the process for assessing this would involve a referral to the RD as well as to the Occupational Therapist (OT) and the OT had not been involved as far as they were aware.

Interview with Nurse Consultant #114, acknowledged that the plan of care for resident #025 had been changed prior to an interdisciplinary assessment including a discussion with the resident regarding the risks involved.

Interview with Assistant General Manager #100 and Director of Nursing Care #101 acknowledged that the eating plan of care for resident #025 had been updated by multiple staff during the course of the inspection and was not consistent with the nutritional care plan of care. The AGM and DONC also acknowledged that the plan of care was not consistent and did not complement each other regarding resident #025's preference for positioning at meals. [s. 6. (4) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Observations of the morning nourishment cart on an identified Neighbourhood found the following:
-Resident #052 was poured 60 ml of apple juice and was listed on the "Snack Delivery Report" to receive "125 ml Pear Drink". The apple juice drink was placed on the table just inside the door of the room without being offered to the resident.
- Resident #069 was poured 80 ml of apple juice and was listed on the "Snack Delivery Report" to receive "125 ml Pear Drink". The apple juice drink was placed on the table just inside the door of the room without being offered to the resident.

During an interview with the volunteer delivering the morning snack cart, they reported that resident #054 was listed to get "125 ml prune juice" but there was none available so they did not provide anything to that resident and wrote on the list "not today".

Review of the "Snack Delivery Report" identified that a labelled snack that had been sent for resident #055 was served to resident #056 instead.

During an interview with Nurse Consultant #114 and FSM #109, it was acknowledged it would be difficult for the staff to mark the accurate amounts of fluids consumed by residents if they did not know how much had been poured into the glasses if the correct amount of 125 ml had not been portioned. The FSM #109 also acknowledged that the prune juice had not been available on the nourishment cart for resident #054. [s. 71. (4)]

Issued on this 7th day of September, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHARON PERRY (155), AMIE GIBBS-WARD (630), DEBORA SAVILLE (192), MARIAN MACDONALD (137)
Inspection No. / No de l'inspection :	2016_448155_0008
Log No. / Registre no:	013963-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jul 15, 2016
Licensee / Titulaire de permis :	Schlegel Villages 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 Schlegel Villages 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) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_448155_0002, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

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

Order / Ordre :

The licensee must take action to ensure that the home's continence care and bowel management program is implemented in the home as required under section 48 of this Regulation.

Grounds / Motifs :

1. This legislation/regulation was previously issued as a written notification and compliance order (CO #002) on March 17, 2016 inspection number 2016_448155_0002.

While the home did develop a continence care and bowel management program, the program had not been fully implemented in the home, as required under section 48 of this Regulation, as confirmed by Assistant General Manager # 100, Director of Nursing Care # 101, Nurse Consultant # 114 and Registered Practical Nurse – Continence Lead # 136.

The written description of the program included a description of the interdisciplinary team to include, but not be limited to: Director of Nursing Care, Assistant Director of Nursing Care, RAI/QI Registered Practical Nurse, Personal Expression Resource Team Lead, Personal Care Aides (minimum 2), Registered Practical Nurse (minimum 2), Registered Nurse (minimum 2), Assistant Director Food Services, Neighbourhood Coordinators, Registered Dietitian, Medical Director, Assistant General manager and Infection Control Lead. It also included that upon admission a detailed three day Voiding and Bowel Elimination record will be completed to determine a detailed record of all continent and incontinent episodes.
The Assistant General Manager # 100, Director of Nursing Care # 101, Nurse Consultant # 114 and Registered Practical Nurse – Continence Lead # 136 all agreed that an integral component of the program was to establish a full complement of members on the team and the completion of the 3 day voiding records.

The continence team held two meetings. The first meeting was attended by the Director of Nursing Care, Registered Practical Nurse – Continence Lead and two Resident Assessment Instrument/Quality Improvement (RAI/QI) staff.
The second meeting was attended by the Director of Nursing Care, Registered Practical Nurse – Continence Lead and a Nurse Consultant – Support Office.

The team had identified a general trend of unsatisfactory completeness of three day Voiding and Elimination Record.
Registered Practical Nurse - Continence Lead # 136 and Registered Practical Nurse # 130 confirmed the 3 day voiding record was to be completed on all new admissions but had not been done.

The licensee failed to ensure that the continence care and bowel management program was implemented in the home, as required under section 48 of this Regulation.

The scope of this area of non-compliance was widespread, was previously

issued as a compliance order, and the severity was determined to be a level 2. (137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 29, 2016

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_448155_0002, CO #003;

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 licensee must ensure that the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs and meets the requirements set out in the Act and this Regulation.

The licensee must assess the resident's care and safety needs on each Neighbourhood.

The licensee must review the home's staffing pattern regarding Personal Care Aide hours on each Neighbourhood and ensure that there are enough Personal Care Aides/direct care staff to meet the residents' assessed care and safety needs.

Grounds / Motifs :

1. This legislation/regulation was previously issued:
-as a written notification, compliance order (CO #003) and Director's referral on

March 17, 2016, inspection number 2016_448155_002;
-as a written notification and compliance order (CO #003) on June 8, 2015, inspection number 2015_217137_0021, and complied on Oct 27, 2015;
-as a written notification and compliance order (CO #001) on May 26, 2014, inspection number 2014_228172_0004 and complied on November 22, 2014 and
-as a written notification and compliance order (CO #001) on March 17, 2014, inspection number 2014_202165_0005.

Resident interviews and call bell response times revealed:

A) Resident #066 shared that there was not enough staff as they have waited over an hour at times. They shared that staff come in and shut off the bell after two or three minutes and say they are going to get help but don't come back for long periods. Resident #066 stated that the wait is the longest in early morning.

Review of the call bell response records indicated that on six occasions the time, between when resident #066 activated the call bell and when it was cancelled, exceeded 10 minutes. On one occasion the call bell was activated for 20:53 minutes and on another occasion the call bell was activated for 21:37 minutes.

B) Resident #006 shared that there was not enough staff. Resident #006 shared that they have had to wait and have waited 10 to 20 minutes and even longer on several occasions. They expressed that staff come in, turn off the bell and leave. It takes awhile for anyone to come back. The longest wait was in the morning. Resident #006 shared that they were late for breakfast as had to wait for staff.

Inspector #137 spoke with Neighbourhood Coordinator # 007 regarding resident #006 not being in the dining room for breakfast. Neighbourhood Coordinator #007 shared that they were monitoring care on the neighbourhood and that it was not possible as they saw resident #006 in the dining room. Inspector # 137 asked Neighbourhood Coordinator #007 to provide the call bell response record.

A review of the call bell response record, indicated that resident #006 activated the call bell at 0841 hours and it was activated for 14:56 minutes. After review of the call bell response record, Neighbourhood Coordinator #006 shared that resident #006 was late for breakfast. Resident #006 shared they did go for breakfast but was late getting to the dining room.

Review of the call bell response records for an identified period of time, indicated that on ten occasions the time, between when resident #006 activated the call bell and when it was cancelled, exceeded 10 minutes. On one occasion the call bell was activated for 18:43 minutes.

C) Resident #068 shared that there was not enough staff and has had to wait like everyone else. They expressed that they have waited many times well over ten minutes.

Review of the call bell response records for an identified period of time, indicated on six occasions the time, between when resident #068 activated the call bell and when it was cancelled, exceeded 10 minutes. On one occasion, the bell was activated for 21:05 minutes, on another occasions the bell was activated for 22:08 minutes and for 29:32 minutes.

D) Resident #069 shared that there was not enough staff and has had to wait for assistance.

Review of the call bell response records for an identified period indicated on two occasions the time, between when resident #069 activated the call bell and when it was cancelled, exceeded 10 minutes.

E) Resident #020 shared that there was not enough staff. They shared that they need staff to help them. They stated that they feel that they wait 15 to 20 minutes when they call for help.

Review of the call bell response records for an identified period of time indicated on six occasions the time, between when resident #020 activated the call bell and when it was cancelled, exceeded 10 minutes. On one occasion the bell was activated for 21:38 minutes.

F) Resident #072 shared that there was not enough staff and that they have to wait 10 to 15 minutes to get help. Resident #072 shared that waiting for help happens before and after meals.

Review of the call bell response records for an identified period of time indicated on 13 occasions the time, between when resident #072 activated the call bell and when it was cancelled, exceeded 10 minutes. On one occasion the bell was

activated for 29:23 minutes.

G) Resident #016 shared that there was not enough staff and they had to wait.

Review of the call bell response records for an identified period indicated on seven occasions the time, between when resident #016 activated the call bell and when it was cancelled, exceeded 10 minutes.

2. Observations during the supper meal service on an identified date, in a dining room found multiple residents who required assistance with eating were served meals prior to having someone available to provide the assistance.

A) Observations of resident #026 during this supper meal found he/she was unable to feed themself without assistance from staff. This resident was served the meal and at that time did not pick up their utensils or start eating. After twenty-two minutes, resident #026 received a verbal cue from PCA #137 and started to eat. No other assistance was offered to resident #026 and they stopped eating their meal 5 minutes later. Resident #026 was observed to eat less than 25 per cent of their meal.

B) Observations of resident #027, during the meal found resident #027 was served their meal and started to feed themself but then left the table shortly after indicating they had to use the washroom. Resident #027 returned, after sixteen minutes, to their meal which was still on the table but did not receive assistance or start eating. Seventeen minutes later, PCA #137 sat down with resident #027 and attempted to assist resident #027, but resident was asleep. Seven minutes later, the main entrée for resident #027 was cleared and they were observed to have eaten less than 25% of the meal. Dessert was served but resident #027 did not feed themself this item and no assistance was provided.

During an interview with PCA #137 it was reported that resident #027 did need assistance with their meal.

Clinical record review for resident #027 showed the plan of care for eating included the following interventions: “he/she may require feeding” and “may need one person extensive assistance".

C) Observations of residents #028 and #029 during the meal found they were each served a meal in an identified time. There were no staff at the table to

provide assistance and they were both unable to start feeding themselves. Twenty-seven minutes later, a PCA sat at the table and provided total assistance with the meal. During an interview it was reported that both residents required total assistance with eating.

3. Observations of the nourishment cart on an identified date, in an Neighbourhood found the fluids and labelled snacks were being served without the assistance of staff. There was no staff observed for twenty minutes while snacks were being delivered. The home's policy titled "Nourishments", states that the nursing team will serve snacks and that snacks will be served at 1000-1100 hours. At 1100 hours, Support Office-Nurse Consultant #114 came to assist. At 1105 hours, the Food Services Manager #109 also came to assist with the morning nourishment cart. Resident #054 was listed to get a specific juice but there was none available so resident #054 did not get any nourishment offered.

Resident #052 was poured 60 ml of juice and was listed on the "Snack Delivery Report" to receive "125 ml Pear Drink". The drink was placed on the table just inside the door of the room without being offered to the resident.
Resident #069 was poured 80 ml of juice and was listed on the "Snack Delivery Report" to receive "125 ml Pear Drink". The drink was placed on the table just inside the door of the room without being offered to the resident.
Review of the "Snack Delivery Report" identified that a labelled snack that had been sent for resident #055 was served to resident #056 instead.

4. A review of the Resident Council meeting minutes, for and identified date, revealed concerns related to staffing shortages on two Neighbourhoods and call bells being turned off, with offer of returning with help, but no one returns for a long time.

Resident #076, shared that there was still a problem with not having enough staff. They shared that one Neighbourhood on evenings was the worst. Resident #076 shared that they go to each Neighbourhood, at least every ten days to observe. They noted that on evenings that one hour after staff start work, staff are going on coffee break. Resident #076 shared, before supper is the time when residents need help to go to the washroom but they have to wait because there is not enough staff around to help. Resident #076 said that they have shared this information with the General Manager but feels that no one

listens.

5. Review of the call bell response records for an identified period of time was done for three neighbourhoods. Review revealed the following:
A) One identified neighbourhood—52 call bells activated for greater than 10 minutes. Twenty occurred during day shift (38%), thirty-one on evening shift (60%) and one on night shift (2%).
B) One identified neighbourhood—56 call bells activated for greater than 10 minutes. Eleven occurred during day shift (20%) and forty-five (80%) occurred during evening shift.
C) One identified neighbourhood----37 call bells activated for greater than 10 minutes. Twenty-two occurred during day shift (59%), eleven on evening shift (30%) and four on night shift (11%).

Interview with the Assistant General Manager #100 and Neighbourhood Coordinator #107 revealed that they were meeting weekly to review all call bells greater than 10 minutes and the maximum wait times on each Neighbourhood for the week. They confirmed that the call bell records revealed that residents are ringing and waiting greater than 10 minutes despite all Personal Care Attendant (PCA) shifts being filled for the identified period on these Neighbourhoods.

Interview with the Assistant General Manager #100 and Neighbourhood Coordinator #107 revealed that there had been twenty-three vacant Personal Care Aides (PCA) positions and that they have hired twenty-nine Personal Care Aides. Assistant General Manager #100 shared that all the master lines for Personal Care Aides had been filled but could not demonstrate how the residents were assessed to determine that the staffing patterns meet the assessed resident needs. The Assistant General Manager #100 confirmed that no additional Personal Care Aide hours have been added to the staffing plan.

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

The scope of this area of non-compliance was widespread, was previously issued as an order with a Director's referral and the severity was determined to be a level 2.

(155)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 05, 2016

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2016_448155_0002, CO #004;

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 action to achieve compliance with O.Reg 79/10, s.73(1) 10. by ensuring staff use proper techniques to assist residents #051, #083 and any other residents requiring assistance with eating, including safe positioning of residents who require assistance.

Grounds / Motifs :

1. This legislation/regulation was previously issued:
-as a written notification, compliance order (CO #004), and Director's referral on March 17, 2016, inspection number 2016_448155_0002;
-as a written notification and compliance order (CO #002) on October 27, 2015, inspection number 2015_217137_0041; and
-as a written notification and compliance order (CO #005) on June 8, 2015, inspection number 2015_217137_0021.

Observations of resident #051 on an identified date, during the meal in the dining room found resident #051 was leaning to the right and leaning forward in the wheelchair while being assisted with food and fluids. There was no table tray in place or other observed positioning devices.

Observations of resident #051 on another identified date, during another meal found resident #051 was leaning to the right with the side of their body leaning on the arm rest and right arm unsupported and dangling down beside the wheel. The wheel chair was observed to be tilted back about 30 degrees from upright position. There was no table tray in place or other observed positioning devices. Personal Care Aide (PCA) #117 was sitting on the left of the resident providing total assistance and was observed to say to resident #051 "can you sit up this way as I can't see your mouth". Resident #051 was observed to cough intermittently during the meal. Twenty minutes after the meal had started, PCA #117 was observed to reposition resident #051 to a more upright position using a blanket.

Interview with RPN #146 acknowledged that resident #051 was not positioned properly for eating.
Interview with RPN #136 identified that the Occupational Therapist had left a note for the physician recommending a device for improved positioning of resident #051. RPN #136 confirmed that after twenty-one days, this recommendation had not been signed off or checked as completed by the physician and the device had not been ordered.

Clinical record review found that on two identified dates resident #051 was seen by the Occupational Therapist who made recommendations regarding device to improve positioning.

Interview with Assistant Director of Nursing Care #131, reported that 100 per cent of staff had completed the mandatory training on feeding assistance which included education regarding safe positioning at meals. Food Services Manager #109 reported that the training for feeding assistance was completed on-line by staff and provided a copy of the education material. Review of the "Supportive Dining: Team Member Training" slide number 1.8 titled "Resident Positioning" stated "we need to strive to place our residents in positions which ensure they sit upright, in neutral". [s. 73. (1) 10.] (630)

2. On an identified date, Personal Care Aide # 120 was observed standing while feeding thickened juice to resident # 083, in a neighbourhood lounge area. The resident was seated and the Personal Care Aide was standing approximately 16 inches above the resident's eye level.

The Personal Care Aide acknowledged that he/she should be seated to assist the resident.

The Director of Nursing Care # 101 (DNC) acknowledged the potential risk and indicated the expectation was that team members were expected to be at the resident's eye level, when assisting residents with eating, to ensure that the resident did not aspirate.
The DNC also shared that all front line staff, including PCA #120, and staff from other departments had received education related to proper techniques to assist residents with eating, including safe positioning of residents who require assistance and the observed practice was not acceptable. [s. 73. (1) 10.]

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

The scope of this area of non-compliance was isolated, was previously issued as a compliance order with a Director's referral and the severity was determined to be a 3.
(137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 29, 2016

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) (b)

Linked to Existing Order / Lien vers ordre existant: 2016_448155_0002, CO #006;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The home shall prepare, submit and implement a plan to ensure that the infection prevention and control program includes that on every shift, symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

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.

The plan must include education of all registered staff regarding monitoring the symptoms indicating the presence of infection and education on the home's process for monitoring.

Please submit the plan, in writing, to Sharon Perry, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Long-Term Care Homes Inspection Division, 130 Dufferin Avenue, 4th Floor, London, ON, N6A 5R2, by email, at Sharon.Perry@ontario.ca by July 22, 2016.

Grounds / Motifs :

1. This legislation/regulation was previously issued as a written notification and compliance order (CO #006) on March 17, 2016, inspection number

2016_448155_0002.

On March 17, 2016, inspection number 2016_448155_0002, CO #006, the licensee was ordered that they must take action to achieve compliance with O.Reg.79/10, s.229.(5)(a) to ensure that on every shift symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices.

Interview with Assistant Directors Nursing Care (ADNC) #131 and #132 identified that it was the expectation that registered staff on each neighbourhood, complete the Daily Infection Control Surveillance record on each shift, listing the first symptoms of infection identified in any resident on the neighbourhood. Auditing for the completion of the Daily Infection Control Surveillance record was being completed daily or every other day by the Assistant Directors of Care to ensure compliance. Information from the 24 hour shift report completed by the Registered Nurse was reviewed daily to ensure any resident with identified symptoms of infection were included on the Surveillance Record.

Daily Infection Control Surveillance records for March and April 2016, were observed. Daily Infection Control Surveillance records for May 2016, were reviewed for each neighbourhood.

Review of an identified Neighbourhood, Daily Infection Control Surveillance record identified that resident #006 was added to the Surveillance Record. Review of progress notes identified a registered staff member documented that resident #006 exhibited signs and symptoms of infection and a note was left for the physician. Interview with ADNC #132 confirmed that it would be the expectation that at the first symptom of infection, a resident was to be added to the Daily Infection Control Surveillance record and that resident #006 should have been added two days earlier.

Review of an identified Neighbourhood, Daily Infection Control Surveillance record identified that resident #007 was added to the Surveillance Record. Resident #007 was started on an antibiotic. Interview with ADNC #132 confirmed that resident #007 should have been added to the Daily Infection Control Surveillance record three days earlier.

A random sampling of records were reviewed from residents not identified on the

Daily Infection Control Surveillance records for three identified Neighbourhoods. Record review identified that resident #012 presented with signs and symptoms of infection on an identified date and four days later was placed on antibiotics. Interview with ADNC #132 confirmed that resident #012 was not included on the Daily Infection Control Surveillance record for the identified Neighbourhood and that the resident should have been included.

Interview with ADNC #132 identified that if registered staff did not communicate to the Registered Nurse that a resident had symptoms of infection, it would not be included in the 24 hour report and there would be no way for the ADNC to confirm that the Daily Infection Control Surveillance record was complete.

The licensee failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The scope of this area of non-compliance was pattern, previously issued as a compliance order and the severity was determined to be a level 2. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 02, 2016

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

Order / Ordre :

The licensee must take action to ensure compliance with O. Reg 79/10, s.68.(2) (c) by ensuring the nutrition care and hydration programs includes the implementation of interventions to mitigate and manage risks.
The licensee must ensure that residents #023, #021 and all other residents who receive thickened fluids, receive the thickened fluids to the consistency ordered by the Registered Dietitian.

Grounds / Motifs :

1. The licensee has failed to ensure that the nutrition and hydration care program included the implementation of interventions to mitigate and manage risks related to nutrition care, dietary services and hydration.

a) Observations during the lunch meal service, in the dining room found RPN #113 was making resident #023 thickened milk and thickened coffee at the table. The thickened fluids were observed to be close to pudding thickness and

appeared lumpy. RPN #113 was observed not to be following the recipe on the "Thicken-Up Clear" container. Resident #023 was observed to be coughing on the fluids after they were given to them by RPN #113.

Interview with the Food Service Manager (FSM) #109 confirmed that the thickened fluids for resident #023 had not been prepared correctly. FSM #109 acknowledged that RPN #113 was not following the correct process for thickening the items for resident #023. FSM #109 was observed to remove the first milk prepared for resident #023 and prepared a new portion. FSM #109 said it was the practice in the home for the staff to prepare the thickened fluids at the table using the recipe on the container or in the nourishment binder. FSM #109 confirmed there was no recipe for staff to refer to in the nourishment binder.

Review of the clinical record for resident #023 found:
-Registered Dietitian (RD) #142 assessment note, that stated resident was having difficulties swallowing" and that fluids were to be nectar thick.
- Plan of care identified that resident was a high nutritional risk and nectar thickened fluids were to be provided.

b) Observations during the meal service, in the dining room found Personal Care Aide (PCA) #111 was making resident #021 thickened water at the beverage cart. The thickened fluid was observed to be close to honey thickness. PCA #111 was observed not to be following the recipe on the "Thicken-Up Clear" container.

Interview with PCA #111 identified that they had not followed the recipe on the "Thicken-Up Clear" container as they thought the recipe did not seem correct for this fluid. The PCA reported that they thought resident #021 required fluids that were between nectar and pudding thickness and that sometimes this resident needed the fluids thinner and other times thicker. PCA #111 said the texture for this resident's fluids were listed in the servery diet list and the plan of care but they did not need to look at these as they knew the residents.

Interview with Food Services Worker #112 identified that the order listed for resident #021 in the servery diet list indicated "nectar thickness".

Review of the clinical record for resident #023 found:
-RD #142 assessment note that stated resident was changed to a high

nutritional risk and placed on a regular fluid trial
- Plan of care identified indicators of high nutritional risk and provide nectar fluids.

During an interview with Neighbourhood Coordinator #110, it was reported that it was the expectation in the home that the thickened fluids prepared by staff and given to residents in the dining room would match the recipe and the plan of care.

c) Review of the Food Services Nutritional Care policy titled "Thickened Fluids" dated June 2010 stated "all hot and cold beverages and soups will be thickened prior to serving at meals as indicated on the resident care plan" and "standardized recipes will be available and followed for thickened fluids".

During an interview with FSM #109, it was reported that they were unsure exactly when the training was provided to the front line nursing staff on how to prepare thickened fluids but thought it was done over two years ago. FSM #109 was unable to produce a record of which staff had attended the in-services on how to prepare thickened fluids. They acknowledged there were concerns with the current process in the home for preparation of thickened fluids and as a result they were planning to switch to purchasing pre-thickened fluids instead of having the staff prepare them at the time of service.

During an interview with the Registered Dietitian (RD) #147, it was acknowledged that serving fluids that were not the correct texture to residents with dysphagia was considered to be a risk issue. The RD identified that they had noticed staff in the home were not preparing the thickened fluids based on the recipe and had brought this to the attention of the FSM through an email earlier in the week. RD #147 indicated it was the expectation in the home that residents with swallowing difficulties would be served the correct texture fluids to help mitigate risks.

The licensee has failed to ensure that the nutrition and hydration care program included the implementation of interventions to mitigate and manage risks related to nutrition care, dietary services and hydration.

The scope of this area of non-compliance was isolated, there was previous unrelated non-compliance and the severity was determined to be a level 3. (630)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 29, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 15th day of July, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SHARON PERRY

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