Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 27, 2016	2016_440210_0008	012693-16	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

SHERWOOD COURT LONG TERM CARE CENTRE
300 Ravineview Drive Maple ON L6A 3P8

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

SLAVICA VUCKO (210), NICOLE RANGER (189), NITAL SHETH (500), THERESA BERDOE-YOUNG (596)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 24, 25, 26, 27, 2016.

With this RQI the following Critical Incident (CI) inspections: staffing 007189-16; infection prevention and control 005302-16; administration of drugs 007718-15, 010683-16; personal care 005403-16, 028487-15, 011974-16; falls 015553-15, abuse/ responsive behaviour 001610-16, 003351-14, 008669-15, 004733-14, 009076-14, 009770-14, 08245-15, 000515-15, 007739-15, 006218-15, 004816-15; 004587-15, 001420-14, 017758-15, 017203-15, 004756-15, 013006-16, 013840-16, 031017-15; transfer 006850-15, 007850-15, 005260-15, 010356-15; and complaints: abuse/responsive behaviour 002835-16, 014933-16; personal care 010746-15, falls 036007-15; staffing 035387-15; infection prevention and control 009737-16; follow up on order for transfer 014771-16, were inspected concurrently.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Regional Manager of Clinical Services, Environmental Manager (EM), Nutrition Manager (NM), Program Manager (PM), Resident Service Manager (RSM), Registered Dietitian (RD), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), dietary aides (DA), activity aides (AA), staffing clerk, housekeeping staff, Residents' Council President, Family Council Secretary, reports analyst from Classic Care pharmacy, residents and family members.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **21 WN(s)**
- **12 VPC(s)**
- **1 CO(s)**
- **0 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
O.Reg 79/10 s. 36.	CO #001	2015_417178_0011	500

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #054 was protected from abuse by anyone and not neglected by the licensee or staff.

Under O. Reg. 79/10, s. 5 for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well being of one or more residents.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

On May 18 2016, an inspection began for a complaint inspection, an allegation of resident to resident abuse. Resident #054 was hit with a plastic object by resident #060. Staff interviews and record review revealed that during the evening of an identified date in 2016, resident #054 was inside a specified area with other residents, when PSW #141 heard screaming and yelling in that area. Upon entering the area, PSW #141 reported he/she observed resident #060 hitting resident #054 with a plastic object. PSW #141 reported that he/she separated the residents and resident #060 continued to yell and scream at resident #054. Resident #054 sustained an injury to a part of his/her body.

During a family conference on an identified date, related to the incident, the home informed the family of resident #054 that the plastic object on the unit will be replaced with a very light plastic material and was ordered for replacement.

On May 19, 2016, the inspector observed yellow plastic objects on the identified unit from 1250 hours to 1500 hours in the t.v lounge area, with multiple residents in the t.v lounge and there was no indication for the objects' use at the time of the observation. Inspector spoke with registered staff #100 who observed the objects in the t.v lounge at 1500 hours and reported that the objects should not be there and immediately removed them.

On May 26, 2016, the inspector observed the plastic object in the dining room on the identified unit at 1027 hours. Inspector observed residents seated in the hallway along the dining room. Inspector spoke with registered staff #109 and inquired if there is any safety concerns the staff should be monitoring for resident #060 and resident #054. Registered staff #109 reported that the instructions he/she received is that if he/she sees the object around resident #060 they should remove it and redirect the resident. Inspector requested registered staff #109 to identify resident #060, and the registered staff identified resident #060 who was sitting at the window, near the dining room and

within vicinity of the object. Inspector asked the registered staff if the object should be there as there was no indication for the object's use at the time of the observation. Registered staff #109 reported it should not be there and immediately removed the object.

During interviews with PSW #126, #141, housekeeping staff #160 and #169, the staff reported that there was a discrepancy as to whose responsibility it was to remove the plastic object when not in use.

The PSW staff reported that the housekeeping staff should remove the plastic object when no longer required, and the housekeeping staff reported that the PSW should also assist with removing the plastic object. Interview with PSW #141 reported that he/she was concerned about the use of the plastic object and resident safety after the incident and spoke with management about this issue. All staff interviewed reported that they were aware of the incident but reported that they did not receive any notification from management about the issue.

Interviews with the Director of Care (DOC) and Executive Director (ED) reveals that the home will replace the plastic object with a softer material. The ED and the DOC confirmed that the abuse had taken place and education is required to staff regarding the safety for the residents with the plastic objects on the unit. [s. 19. (1)]

2. On May 18 2016, an inspection began for a complaint inspection, an allegation of resident to resident abuse. Resident #054 was punched by resident #061.

On an identified date, resident #054 was sitting in the dining room. Registered staff #163 reported that he/she was passing the dining room, when he/she observed resident #061 standing over resident #054. Resident #061 took his/her left hand and held resident #054 neck, then took his/her right hand and punched resident #054. Registered staff reported that he/she went to get another staff to assist to separate the residents. Registered staff #109 reported that this was the third incident involving resident #061 and they were having difficulty managing resident #061 behaviours.

Interviews with the Executive Director and the Director of Care confirmed that the abuse had taken place. [s. 19. (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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

A review of Critical Incident Report (CIR) dated July 11, 2015, indicated resident #052 was not provided proper care.

According to the CI, on an identified date, resident #052 got out of the identified unit. The resident then went out the front door of the building. A housekeeper was present and went out after the resident. A family member was outside and went back in to get staff to help get the resident back into the building while the housekeeper stayed with the resident. There were three staff members who came out to help with getting the resident

into the building. When the management reviewed the video surveillance, they observed that the resident was resistive to coming back into the building. Two staff had the resident by his/her arms and pulled him/her into the building and continued to pull him/her across the foyer against his/her will.

On May 18, 2016, the inspector reviewed the video surveillance that recorded the incident on the identified date. Resident #052 was seen pushing the main door glass open and able to exit the main door which was unlocked.

Housekeeping staff #154 was observed exiting the home and proceeded to go outside to the resident. A visiting family member entered into the home and was then seen with RPN #113 who was on duty at the time of the incident, exiting the front door with PSW #105 and PSW #108.

Approximately four minutes later, RPN #113 and PSW #108 were seen bringing the resident back inside the home, both staff at the resident's side holding the resident under his/her arms. Once at the vestibular area, the resident was observed resisting entering the home and was pulling the arm of RPN #113. As the resident was resisting entering into the main foyer of the home, both RPN #113 and PSW #105 were observed pulling the resident into the home as he/she was resisting.

Interview with RPN #113 and PSW #105 reported that they were given a suspension from the home as they did not use Gentle Persuasive Methods with the resident. Interview with previous ED confirmed that the manner in which the staff members handled the resident during this incident did not show courtesy and respect. [s. 3. (1) 1.]

2. A review of Critical Incident Report dated March 25, 2015, indicated resident #050 was not provided proper care.

According to the Critical Incident (CI), on an identified date PSW #104 was assigned to provide care to resident #050 on the evening shift. RN #100 reported to the inspector that on that day as he/she was completing his/her rounds, he/she noticed the spa room door open, and he/she went inside and found resident #050 sitting on a shower chair, wet and naked except for a towel on his/her head and one across his/her chest. RN #100 also reported that the resident was unattended and was crying. RN #100 said he/she comforted the resident and stayed with him/her for three minutes until PSW #104 arrived. Registered staff reported to the inspector that he/she informed the PSW that this was serious and the resident should not have been left unattended.

Interview with PSW #104 confirmed the above incident. Interview with resident #050's POA revealed that the resident was upset about the incident. Interview with previous ED and DOC confirmed that the resident's right to be treated with courtesy and respect was not promoted. [s. 3. (1) 1.]

3. A review of Critical Incident Report dated May 19, 2015, indicated resident #053 was not provided proper care.

According to the CI, on an identified date, resident #053 reported to the previous Resident Service Manager (RSM) and ADOC that he/she did not sleep the night before because of the care he/she received from PSW #161. The resident reported that PSW #161 attempted to transfer him/her from the wheelchair to the bed without using the standing lift and without a second person to assist. The resident reported that he/she insisted that the PSW use the lift, for which the PSW was angry when he/she left the room to get the lift. The resident reported that the PSW did bring the lift and a second person and transferred the resident to the bed. The resident reported that the PSW did not provide care to the resident for the remainder of the shift and the resident was afraid to use the call bell, nervous that the PSW may yell at him/her.

During an interview with the resident, he/she reported to the inspector that on an identified date, when he/she spoke with the management about the incident with PSW #161, he/she informed the management that he/she does not want PSW #161 to provide care to him/her anymore. The resident reported to the inspector that after the meeting with the management, a few days later he/she was surprised to see that PSW #161 was still assigned to provide care to him/her, and provided care to him/her for about one week after the incident.

The inspector reviewed the daily task flow worksheet for an identified period of 12 days, and documentation revealed that PSW #161 did provide care to resident #053 as documented by the PSW on four identified dates. The inspector also reviewed the home's Client Service Response Form (CSR) and confirmed that the resident reported to the RSM and ADOC that he/she did not want PSW #161 to provide care to him/her anymore.

Interview with the DOC who was the ADOC at the time of the incident confirmed the resident did express concern related to the care he/she received from PSW #161, and that PSW #161 did provide care to the resident after he/she reported he/she did not want

the PSW to care for him/her.

The DOC confirmed that the resident's rights were not respected and promoted. [s. 3. (1) 1.]

4. The licensee has failed to ensure that every resident's right to be protected from abuse is fully respected and promoted.

A review of the Critical Incident Report submitted to the MOHLTC, reported that a family member was visiting his/her loved one when resident #021 walked into his/her loved one's room and laid down on the bed. The CIR indicated that the family member grabbed resident #021 from behind and pushed him/her out of the room while grabbing his/her arm.

Interview with family member #165 revealed that on an identified date, resident #021 wandered into resident #003's room and he/she tried to get the resident out of the room by holding and pushing the resident #021 by the shoulders. The resident was screaming and didn't want to leave the room, but eventually left.

Interview with PSW #164 revealed that on the identified date, he/she observed family member #165 in the corridor near resident #003's room, holding onto resident's hand while resident was screaming and crying. PSW #164 proceeded to take resident and reassured him/her near the nursing station.

Interview with Environmental Manager (EM) #112 revealed that he/she was doing a walkabout in the home on the same identified date and noticed family member #165 pulling resident #021 in the hallway by one arm holding onto his/her forearm, and speaking loudly in the corridor. Resident #021 was resisting, yelling and was agitated. EM reported that he/she stated to family member "stop, you can't do that."

Interview with the home's previous ED #129 revealed that an investigation was completed regarding the allegation of abuse between family member #165 and resident #021, including an interview with the family member. Family member #165 admitted to physically removing resident #021 from resident #003's room. ED #129 reported that the outcome of the home's investigation was that abuse was found. [s. 3. (1) 2.]

5. The licensee has failed to ensure that every resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs is fully

respected and promoted.

A review of Critical Incident Report dated February 23, 2015, indicated resident #40 was not provided proper care. According to the CIR on an identified date, the POA for resident #040 arrived at the home at 0800 hours and found the resident in the bed. The POA approached registered staff #113 to inquire as to when care will be provided to the resident. The registered staff reported to the POA that the unit is short staffed. The POA spoke with the ED who then assigned a PSW to provide care to the resident.

Interview with the previous ED confirmed that the family member did express concern related to the care of the resident, and that the registered staff should have provided a staff to care for the resident when requested.

On an identified date, PSW #152 was assigned to provide care to resident #040. The resident's POA/daughter reported to the home that upon arrival into the resident's room, he/she found the resident did not have his/her dentures in and asked the registered staff member #113 who was providing care to the resident. Registered staff #113 informed the POA that PSW #152 was assigned to provide care to the resident.

The POA informed RN #113 that he/she previously requested PSW #152 to not be assigned to provide care to the resident and requested registered staff to change the PSW assignment. The POA later returned to the home and discovered that the PSW was still assigned to the resident.

Interview with RPN #113 revealed that he/she had a discussion with the PSW's on the unit, and decided since PSW #152 already provided morning care to the resident, he/she would keep the assignment as it was and confirmed that he/she did not change the assignment.

Interview with the DOC and record review of the home's Client Services Response Form confirmed that the family member did express concern about the incident, and that the registered staff should have reassigned the PSW assignment as requested by the family member and his/her choice to be respected. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, and that every resident's right be protected from abuse is fully respected and promoted, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

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

A review of the Critical Incident Report indicated a resident to resident alleged abuse. The home initiated investigation for alleged abuse; notified the police and the Power of Attorney (POA) of both residents. Interview with PSW #166 indicated resident #043 and #044 are moderately cognitively impaired and are usually enjoying the company of each other in the dining room. The staff indicated that after the incident of alleged abuse both residents should be monitored if they go in their rooms. Staff further indicated that every morning before breakfast resident #043 goes into resident #044's room and waits there for staff to give him/her care and they go together to the dining room for breakfast. Further staff #166 indicated that his/her practice is to give morning care to resident #044 first then to resident #043 in order resident #043 does not go in resident #44's room and stay in the room. Interview with RN # 133 indicated he/she was not aware that resident #044 should receive morning care before resident #043. Interview with RN #109 revealed he/she was not aware if resident #043 and resident #044 were allowed to stay together in the dining room. Interview with DOC revealed when the alleged abuse investigation outcome was communicated to resident #043 and resident #044's POAs they allowed both resident to stay together in the dining room but not in their rooms and that they should be monitored frequently.

A review of resident #043's written plan of care and interviews with RN #109, PSW #133, PSW #166 and DOC confirmed that the plan of care did not set clear directions to staff and others who provide direct care to the resident in regards to monitoring of resident #043 and #044 and not to be allowed to be left alone in their rooms. [s. 6. (1) (c)]

2. A review of Critical Incident Report dated April 22, 2016, indicated resident #041 was not given oral care particularly the dentures were not removed in the evening of an identified date, and applied again the next day.

Interview with resident #041 revealed the resident had an upper denture that required to be removed in evening and applied in the morning when oral care was performed.

A review of resident #041's written plan of care revealed the resident required support for oral hygiene and needs as evidenced by inability to complete task independently due to physical limitations. The resident required regular manual toothbrush and assistance of

one staff to brush his/her teeth.

A review of the initial and quarterly Minimal Data Set (MDS) assessments did not include information regarding whether or not the resident has dentures and/or removable bridge. Interview with PSW #135 revealed staff has access to the kardex in order to know about resident's oral care and if the resident has dentures. Interview with RPN #134 indicated the resident has dentures and confirmed that resident #041's upper denture was not indicated in the written plan of care. [s. 6. (1) (c)]

3. The written plan of care for resident #005 did not have any information related to the resident's sleep patterns and preferences.

A review of the progress notes indicated on an identified date the resident spent the night in reclined wheelchair and close to the nursing station for monitoring. On another identified date, at 2201 hours the resident was in the wheelchair and being restless. On third identified date, at 2135 hours the resident was asleep on the chair.

A review of the written plan of care and interview with RPN #111 confirmed the written plan of care did not contain interventions for resident #5's sleep patterns and preferences. [s. 6. (1) (c)]

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

An interview with resident #10's family member revealed the resident did not receive a specified dietary intervention at lunch and dinner for approximately two weeks as discussed and agreed with the registered Dietitian (RD) on an identified date.

A review of resident #10's written plan of care revealed on an identified date, the RD updated the nutrition section of the care plan the resident to receive specified dietary intervention for lunch and dinner.

Interviews with PSW #155 and dietary aid (DA) #156 indicated the resident was not receiving the specified intervention for lunch and they were not aware that he/she should be.

Interview with RD #157 revealed that the expectation is if dietary needs change to a resident a request is sent to the nutrition manager (NM) in the communication book and

by email, in order the resident diet be updated in the binder located at the servery in order the dietary aids serve the right diet to the resident. Interview with NM #158 indicated the resident #010's diet was not updated in the diet book on the unit and the resident did not receive the food as recommended by RD.

Interview with DOC, Staff #155, #157 and #158 confirmed that resident #010's diet was not provided to the resident according to the written plan of care. [s. 6. (7)]

5. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Stage 1 resident quality inspection (RQI) staff interview revealed that resident #003 had altered skin integrity on an identified part of the body.

A review of the physician's order for resident #003's skin alteration indicated to change resident's dressing every two days. A review of resident #003's Treatment Administration Record (eTAR) for an identified month indicated that staff did not sign off on an identified date.

Interview with RPN #122 revealed that he/she changed resident #033's dressing on an identified date and forgot to sign off on the eTAR.
A review of the physician's order for resident #003's alteration indicated to change resident's dressing every two days. A review of resident #003's TAR for an identified month indicated that staff did not sign off on an identified date. [s. 6. (9) 1.]

6. Stage 1 family interview revealed that resident #007 was not always receiving bathing as required. A review of the resident list on an identified unit indicated that resident #007 should be bathed on two particular days during the week. A review of resident #007's point of care (POC) bathing report for an identified period of one month, revealed no sign off for shower given to the resident on an identified date.

Interview with PSW #126 revealed that he/she worked on the day shift on the above mentioned date, bathed the resident and didn't sign off in the point of care (POC) documentation. [s. 6. (9) 1.]

7. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months.

A review of two resident #001's admission/quarterly continence assessments, revealed that they were not completed, nor any further assessments were completed.

Interview with the DOC revealed that the above mentioned assessments for resident #001 were not completed and should have been done quarterly. [s. 6. (10) (b)]

8. During stage 1 resident quality inspection (RQI) continence care triggered for resident #007 and review of the resident 's written plan of care, kardex and MDS assessment revealed that the resident required limited assistance on/off the toilet with one staff.

Interview with PSW #133 and PSW #126 revealed that resident was independent with toileting, and the care plan needed to be updated.
A review of resident #007's clinical record and interview with RPN #113 revealed that a continence assessment for resident #007 was completed upon admission, then again six months later. No further continence assessments were completed.

Interview with RPN #113 and the DOC revealed that residents' continence assessments should be completed quarterly and an assessment was not completed three and nine months after the admission, for resident #007. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident, the care set out in the plan of care provided to the resident as specified in the plan, the provision of the care set out in the plan of care was documented, the resident was reassessed and the plan of care reviewed and revised at least every six months, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy Prevention and Management of Specific Infectious Diseases was complied with.

A review of the Prevention and Management of Specific Infectious Diseases policy, dated January 2014, revealed a screening for specific Antibiotic Resistant Organisms (AROs) on admission to the home will be conducted as per regional/provincial requirements and guidelines. In the event a resident is positive for an ARO, the nurse will notify the Infection Control Coordinator/designate in the home, implement additional precautions in addition to routine practices if required and as per regional /provincial guidelines, post signage and provide residents/families/visitors and staff information regarding any additional precautions to take and any personal protective equipment that should be worn.

A review of resident #006's clinical record revealed on an identified date, the resident's lab results were positive for ARO. Interview with PSW #123 and RPN #111 revealed they were not aware that the resident was positive for ARO and that staff required personal protective equipment (PPE) when giving direct care to the resident. Observation on May 11, 2016, at 1300 hours indicated there was no sign for contact precautions on resident #006's door.

Interview with Infection Prevention and Control leader indicated he/she was not informed about the resident #006's lab ARO positive results and confirmed that the policy Prevention and Management of Specific Infectious Diseases was not complied with. [s. 8. (1)]

2. On May 11, 2016, the inspector observed an intact tablet in a medication cup for

resident #054 on the table in the dining room beside the resident.

A record review for resident #054 revealed that on an identified date, an order was written by the physician for the resident to receive a medication, one tablet by mouth, three times a day, as needed. Interview with registered staff #109 confirmed that he/she did not check to see if the resident had taken the medication and confirmed the error. The registered staff also confirmed after review with the inspector that he/she did not sign off for the medication as required.

A review of the home's policy "Medication Administration", LTC-F-20, procedure 15, revised January 2016, directs the registered staff that all medications administered, refused or omitted will be documented immediately after administration on the paper/electronic MAR/TAR using the proper codes by the administrating nurse.

Interview with the DOC and RN #109 confirmed that the home's process is to have the registered staff sign for the administration of medication once given. The registered staff confirmed that the policy for medication administration was not complied with. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the policy "Prevention and Management of Specific Infectious Diseases" and "Medication Administration" were complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

A review of the Critical Incident Report revealed that a Registered Nurse was not on duty at the home on February 29, 2016, during the night shift. Record review and interview with the Director of Care regarding 24 hour nursing care confirmed the following:

There was no registered nurse on duty at the home on the following dates and times:
0700-1500 hours, on February 21 and April 16, 2016,
1500-2300 hours, on February 29, April 16, and April 17, 2016,
2300–0700 hours, on February 29, 1016,
1000- 1300 hours, on May 14, 2016. [s. 8. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside area that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be equipped with a door access control system that is kept on at all times.

Critical Incident Report described a critical incident for failure of the door access control system. According to the CIR, on an identified date and time, resident #052 was able to exit the home via the main doors which were unlocked and were equipped with a door access control system.

On May 18, 2016, the inspector observed the door access control system consisted of two magnetic plates attached to the top frame of the door that operated in conjunction with a key pad. The doors were tested for function and connectivity to the resident-staff communication and response system. A designated code was entered on the key pad and the magnets released temporarily and allowed the doors to be used for entry or egress.

On May 18, 2016, the inspector reviewed the video surveillance that recorded the incident, and the resident was seen pushing the glass door open without pressing in a

key code and did not follow anyone else out the door. Housekeeping staff #154 appeared to be observing the resident as the resident exited the home and followed the resident outside. A visiting family member entered into the home and was then seen with registered staff #113 who was on duty at the time of the incident, exiting the front door with PSW #105 and PSW #108. Approximately four minutes later, registered staff and PSW's were seen bringing the resident back inside the home. The registered staff was observed resetting the magnetic locks on the door by using a key that was inserted into a switch near the door. The door was tested and determined by the nurse that the doors were locked.

During the inspection, the day shift nurse, PSW's and the Environmental Manager (EM) were interviewed to determine the reason for the loss of power to the magnetic plates on the main doors. According to the EM, the home's generator was not activated on the date of the incident which would have switched on within five minutes. RPN #113 was not able to remember if the lights switched off, whether the fire doors in the corridors released or whether other exits were affected. The act of resetting the magnetic locks was an indicator that the doors were deactivated at some point and staff were not made aware of the system failure in any way (whether by a visual or audio cue). The door access control system therefore did not remain on at all times and the reason for its failure could not be established by the licensee. [s. 9. (1) 1. ii.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside area that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be equipped with a door access control system that is kept on at all times, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system be easily seen, accessed and used by residents, staff and visitors at all times.

Observation on May 4, 2016, at 1121 hours, by inspector #500, revealed the call bell in an identified room did not activate when the red button at the end of the extension cord was pressed. This was confirmed with PSW #110. Staff indicated resident #009 is able to use the call bell when he/she requires help.

Observation on May 10, 2016, at 1130, revealed the call bell for resident #009 did not work when the red button at the end of the extension cord was pressed. This was confirmed by staff, RN #109, PSW #110, PSW #105, and EM.

Interview with EM revealed when the call bell does not work the expectation is staff to send a requisition for repair to maintenance using the on-line system that is available to all staff. He/she confirmed that the call bell in room #1115 did not activate when the red button at the end of the extension cord had been pressed by staff or the resident. [s. 17. (1) (a)]

2. Observation on May 20, 2016, at 1300 hours, in an identified room, revealed the call bell did not have a cord connected to the call bell system on the wall. PSW # 155 found the cords in the night table drawer. The DOC confirmed that neither the call bell cord nor the bed alarm were connected.

A review of the resident #10's written plan of care revealed the resident was at risk for falls and some of the interventions to prevent falls were the call bell/light cord to be within reach and a bed alarm applied.

Observation and interview with EM and the DOC confirmed that resident #10's bed alarm could not be easily seen, accessed, and used by the resident at all times. [s. 17. (1) (a)]

Additional Required Actions:

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

WN #8: 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).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written description of the personal support services program that included goals and objectives.

According to s. 8(2) of the Act, personal support services means services to assist with the activities of daily living including personal hygiene services and includes supervision in carrying out those activities.

A record review of the nursing and personal support services program and interview with the DOC revealed that the home did not have a written description of the personal support services program that included goals and objectives. [s. 30. (1) 1.]

2. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions, were documented.

A review of resident #001's clinical record revealed that the resident was admitted to the home on an identified date and the resident's admission continence assessment was incomplete. A review of the resident's quarterly continence assessment for the following two quarters, revealed that they were not completed.

Interview with the DOC revealed that the above mentioned assessments for resident #001 were not completed and should have been. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there was a written description of the personal support services program that included the following: goals and objectives, relevant policies, procedures and protocols, and methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources, any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions, were documented, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of resident #003's clinical record revealed that the resident had three areas of altered skin integrity on three identified body parts.

Record review and interview with RPN #127, the wound care nurse, revealed that the resident's first alteration was discovered on an identified date, and the other two were chronic since one year ago.

A review of the resident #003's weekly wound assessments revealed that two alterations were assessed on an identified date and not again until three months later.

Interview with RN #100, and RPN #127 confirmed that resident #003's altered skin integrities were not assessed weekly as mentioned above. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the program included an annual resident satisfaction evaluation of continence care products in consultation with residents, substitute decision-makers and direct care staff.

Record review and interview with DOC revealed that an annual satisfaction evaluation of continence care products was not conducted with direct care staff in 2015. [s. 51. (1) 5.]

2. The licensee has failed to ensure that residents were provided with a range of continence care products that promote resident comfort, ease of use, dignity and good skin integrity.

A review of the home's resident continence product list indicated that resident #001 wears an identified incontinent product on the day and evening shift, and a different incontinent product on the night shift.

Interview with resident #001 revealed he/she was not wearing the identified day/evening incontinent product as the staff do not always provide them.

Interview with PSW #107 revealed that on May 29, 2016, during the day shift he/she changed the resident in the morning using an incontinent product different from what was listed on the residents' continence product list.The PSW reported that he/she did not find any the identified incontinent product stored in the resident's room, and that he/she should have asked the nurse for the identified incontinent product, but he/she did not. [s. 51. (2) (h) (iii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the program included an annual resident satisfaction evaluation of continence care products in consultation with residents, substitute decision-makers and direct care staff, residents were provided with a range of continence care products that promote resident comfort, ease of use, dignity and good skin integrity, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

On an identified date, the POA for resident #050 made a complaint to the home that his/her mother reported that he/she was slapped by a staff member, and did not receive care from the staff in the evening.

A review of the home's Client Service Response (CSR) form for the identified period of complaint revealed that there was no documented record of the complaint received, nor the type of action taken to resolve the compliant, including the date of the action, time frames for actions to be taken and any follow up actions required, the final resolution if any, and any response made in turn by the complainant.

Interview with the DOC confirmed that there is no documented record of the POA complaint. [s. 101. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff were provided training in skin and wound care.

A review of the home's training records for 2015 and interview with staff #128, the leader of the education program, confirmed that 47 out of 76 staff were not provided training in skin and wound care. [s. 221. (1) 2.]

2. The licensee has failed to ensure that training was provided related to continence care and bowel management to all staff who provide direct care to residents on either an annual basis, or based on the staff's assessed training needs.

A review of the home's training records for continence care and bowel management in 2015 indicated that 58 out of 76 staff were not trained. Interview with staff #128 confirmed that 58 out of 76 staff were not provided training related to continence care and bowel management in 2015. [s. 221. (1) 3.]

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 direct care staff were provided training in skin and wound care, training was provided related to continence care and bowel management to all staff who provide direct care to residents on either an annual basis, or based on the staff's assessed training needs., to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participates in the implementation of the Infection Prevention and Control program.

Observation on May 3, 2016, at 1218, 1222, and 1252 hours revealed that PSW #105 cleared soiled soup bowls and washed his/her hand in the soiled soap water left on the dirty utility cart. PSW #105 wiped his/her hand to the clean clothing protector bag lying on the servery counter and serving other residents.

The inspector observed PSW #110 did not perform hand hygiene after clearing dishes at 1227 hours. At 1242 hours, PSW #110 was observed to be clearing dishes and washing his/her hands in the soiled soap water.

Interview with Dietary Aide (DA) #117 revealed that the soap water left on the cart was for soiled cuttleries and bowls and not for hand washing. Staff should not use that water to wash their hands.

Interview with PSW #105 and #110 confirmed that they should not use soiled soap water

to wash their hands, they should have washed their hands in the sink or use the sanitizer.

Interview with RN #114 confirmed that using soiled water for washing hands is not appropriate and staff should have used the hand sanitizer.

Interview with the NM, RD, and DOC confirmed that staff are expected to follow proper hand hygiene in the dining room. [s. 229. (4)]

2. A review of the Critical Incident Report revealed an incident in regards to a needle stick injury and improper /incompetent treatment of a resident that resulted in risk to a resident. On an identified date and time, resident #042 had a needle inserted under the skin. When PSW #147 performed care to the resident, the needle came out of the resident and the staff sustained a needle stick. He/she reported the incident to RN #147. Further, the same needle was reinserted back into the resident skin by RN #146.

Interview with staff #121, the Regional Manager of Clinical Services, revealed that since September 2014, the home follows the regional company practice about using safety engineered needles only. Interview with the DOC revealed that all non-safety needles were removed from the facility such as the main storage room and the medication rooms on the units.

Interview with RPN #149 revealed on February 14, 2016, he/she used a butterfly needle that was available in the medication room on the unit. He/she indicated that he/she was not aware that there was a policy about using only safety engineered needles and no education was provided to staff. After the incident on February 16, 2016, the nursing staff was informed about the expectation that only safety engineered needles are to be used.

Interview with DOC, staff #121 and #147 confirmed that the staff did not participate in the implementation of the infection and prevention control program applying safe practices. [s. 229. (4)]

Additional Required Actions:

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

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

A review of a Critical Incident Report submitted to the MOHLTC on March 26, 2015, revealed a visitor to resident abuse. The CIR was updated on an identified date, and the results of the home's abuse investigation were not reported to the Director.

Interview with the DOC confirmed that the results of the home's abuse investigation were not reported to the Director as it was missed. The DOC indicated that the home will update the CIR.. [s. 23. (2)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The license failed to ensure that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident is immediately reported to the Director.

A review of a Critical Incident Report dated February 16, 2016, revealed an incident in regards to a needle stick injury and improper /incompetent treatment of a resident that resulted in risk to a resident. On an identified date and time, resident #042 had a needle inserted under the skin. When PSW #147 performed care to the resident, the needle came out of the resident and the staff sustained a needle stick. He/she reported the incident to RN #147. Further, the same needle was reinserted back into the resident skin by staff #146.

Interview with DOC revealed that a Workplace Incident Report was filled by PSW #147 and RN #146 on the same day of the incident. PSW #147 reported the incident to the DOC the following day. Interview with DOC confirmed that the incident was not immediately reported to MOH. [s. 24. (1) 1.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the 24-hour admission care plan was based on the resident's assessed needs and preferences and on the assessments, reassessments and information provided by the placement co-ordinator.

A review of resident #040's clinical record revealed the resident was admitted on an identified date, and no 24-hour admission care plan was created based on the resident's assessed needs and preferences. Interview with the DOC indicated that during admission of residents the expectation is a "Resident Admission Assessment/Plan of Care" form to be completed.

A review of the resident #40 clinical record and interview with the DOC confirmed that the 24-hour admission care plan was not created for resident #40 during admission of the resident. [s. 24. (4)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 25. Initial plan of care

Specifically failed to comply with the following:

s. 25. (1) Every licensee of a long-term care home shall ensure that,
(a) the assessments necessary to develop an initial plan of care under subsection 6 (6) of the Act are completed within 14 days of the resident's admission; and O. Reg. 79/10, s. 25 (1).
(b) the initial plan of care is developed within 21 days of the admission. O. Reg. 79/10, s. 25 (1).

Findings/Faits saillants :

1. The license failed to ensure that the initial plan of care is developed within 21 days of the admission.

A review of resident #040's history of written plans of care revealed the initial written plan of care was developed three months after the admission of the resident.

Interview with the DOC indicated the written plan of care is initiated at admission, developed within 21 days from a resident's admission, and reviewed and updated quarterly or if the resident's health status changes.

A review of the clinical record and interview with DOC confirmed that resident #040's initial written plan of care was not developed within 21 days of the admission. [s. 25. (1) (b)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1.The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's dental and oral status, including oral hygiene.

A review of resident #40's clinical record revealed the resident was admitted to the home on an identified date. A review of the initial progress note revealed the resident had dentures and the dentist was in the home to adjust his/her dentures. Interview with the DOC indicated that the written plan of care is initiated at admission, completed at six weeks from a resident's admission, and reviewed and updated quarterly or if the resident's health status changes.

A review of resident #040's minimum data set (MDS) assessment from an identified date, revealed the resident had dentures or removable bridge. A review of the resident #40's quarterly written plans of care revealed that the dentures (upper and lower) were first time documented 10 months after the admission.

A review of the clinical record and interview with DOC confirmed that resident #40's written plan of care did not contain resident's dental and oral status including oral hygiene for 10 months, since the admission. [s. 26. (3) 12.]

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

A review of resident #044's written plan of care revealed no interventions for resident's sleep patterns and preferences. Interview with PSW #166 revealed he/she was usually giving morning care to resident #044 at 730 hours as the resident was already awake at that time and ready to get up.

Interviews with DOC, PSW #166 and RN #109 confirmed that resident #044's written plan of care did not contain interventions for sleep patterns and preferences. [s. 26. (3) 21.]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council, if any, in developing and carrying out the satisfaction survey, and in acting on its results.

Interview with the president of the Residents' Council revealed that the home did not ask for the opinion of the Residents' Council in developing and carrying out the satisfaction survey.

Interview with the Program Manager (PM) who is the assistant of the Residents' Council confirmed that the home did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey in 2015. [s. 85. (3)]

2. The licensee has failed to ensure that the licensee seeks the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

Interview with the ED and the PM revealed that the home was supporting meetings of the Family Council, known as a Family Forum, every three months, and the satisfaction survey results were shared at the Family Council meetings. The Family Council did not have a President or Vice President elected because of lack of interest, but involvement was encouraged by the home.

A review of the Family Council meeting minutes and interview with the ED confirmed that the licensee did not seek advice of the Family Council in development and carrying out the satisfaction survey and in acting on its results. [s. 85. (3)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug has been prescribed for the resident.

A review of Critical Incident Report indicated that on an identified date, a nurse administered medications prescribed for resident #023 to resident #022 in error. Record review of resident #022's electronic medication administration record (eMAR) for an identified period and physician orders revealed that an identified medication was not prescribed for the resident. Record review of resident #023's MAR for the identified period and physician orders revealed that the identified medication was prescribed for the resident. Review of both identified residents' clinical records revealed that they had similar names.

Interview with registered RN #145 revealed that on an identified date he/she administered the identified medication and other medications in the same pouch which were ordered for resident #023, to resident #022 in error. RN #145 reported that both residents #022 and #023 had similar names and he/she got distracted while administering their medications, leading to the error. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A review of CIR submitted to the MOHLTC, revealed improper/incompetent treatment of a resident that resulted in harm or risk to a resident. Record review of the home's investigation notes and a medication incident report completed by the home, revealed that on an identified date, physician #162 wrote an order to increase resident #024's medication from 40 mg to 60 mg once daily for ten days. Then the medication 40 mg was

to resume. The physician documented the assessment of resident #024 and increase of medication in the resident's progress notes. Pharmacy processed the order, discontinued the resident's previous order of medication 40 mg and started the new order of 20 mg for ten days, then discontinued the medication completely. A review of the physicians order for resident #024 indicated "medication 20 mg, once daily for ten days. Resident #024's progress notes revealed that another identified physician assessed the resident on one month later, due to specified signs and symptoms. This physician found that the resident had been receiving medication 40 mg once daily and after being initially assessed by the physician, the medication was to be increased by 20 mg for ten days then back to 40 mg once daily. The physician found that after the ten days the resident was no longer receiving the medication, as it was discontinued by pharmacy; a medication error had occurred.One month after the initial order, he/she immediately reordered the medication for resident #024.

A review of the resident's eMAR for identified month revealed that the resident had been receiving medication 40 mg once daily, then 20 mg once daily for ten days, then it was discontinued and restarted two weeks later.

Interview with staff #144 from Classic Care pharmacy revealed that the pharmacy interpreted physician #162's initial order for resident #024 for medication 20 mg once daily for ten days, to replace the existing order of medication 40 mg once daily. Physician #162 did not indicate to increase the current dose of medication by 20 mg for ten days in the order, and a medication error had occurred.

Interview with staff #121 (the Regional Manager of clinical Services) and the DOC revealed that a medication error had occurred for resident #024. The home's investigation notes, and interview with physician #162 confirmed that he/she intended to increase resident #024's medication by 20 mg for ten days, then resume the 40 mg once daily dose. The pharmacy processed the physician's order of medication 20 mg once daily for ten days then discontinued it completely. [s. 131. (2)]

3. On May 11, 2015, at 1530 hours, the inspector was conducting an interview with registered staff #113 in the dining room. After the interview, the inspector passed by resident #054 table and noticed a white medication cup on the table. Upon closer observation, the inspector observed one white pill that was intact and not dissolved.

A review of resident #054's clinical record revealed that on an identified date, an order was written by the physician for the resident to receive a medication, one tablet by

mouth, three times a day as needed. Interview with registered staff #109 confirmed that he/she did not check to see if the resident had taken the medication and confirmed the error. The registered staff also confirmed that after the review with the inspector he/she did not sign for the medication as required.

Interview with the registered staff confirmed that the resident did not receive his/her medication in accordance with the direction for use specified by the prescriber. [s. 131. (2)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that:
(a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed
(b) corrective action is taken as necessary, and
(c) a written record is kept of everything required under clauses (a) and (b).

A review of CIR submitted to the MOHLTC, revealed a medication error on an identified date, involving resident #022. The resident was administered medications prescribed for resident #023 in error. Both residents, #022 and #023, had the same last name. Record review of the home's investigation notes and resident #022's clinical record did not include a medication incident report or any corrective action for the medication error that occurred on on identified date.

Interview with the DOC confirmed that the home is unable to locate the medication incident report, unsure whether the medication error was documented on the medication incident report and faxed to the pharmacy, nor was it analyzed.

Interview with staff #144 from Classic Care pharmacy revealed that the pharmacy was not aware of the medication error for resident #022 as they were not notified by the home, and it was not included in the home's medication incident review. [s. 135. (2)]

Issued on this 6th 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) :	SLAVICA VUCKO (210), NICOLE RANGER (189), NITAL SHETH (500), THERESA BERDOE-YOUNG (596)
Inspection No. / No de l'inspection :	2016_440210_0008
Log No. / Registre no:	012693-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 27, 2016
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	SHERWOOD COURT LONG TERM CARE CENTRE 300 Ravineview Drive, Maple, ON, L6A-3P8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Angela Di Mambro

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

Develop, submit and implement a plan to ensure the following:

a) Develop and implement steps to ensure that resident #054 and all residents in the home are protected from abuse and/or neglect by the staff, including training and/or retraining on the home's policy to promote zero tolerance of abuse and neglect of residents, and training related to the requirements to provide care to all residents, as identified in their plan of care.
b) Ensure all staff are educated on how to identify environmental hazards and safety for residents.
c) Develop and implement a schedule to test and monitor staff compliance with the home's abuse policies and environmental risks.
d) Maintain a record of who completed the required retraining, when the retraining was completed and what the retraining entailed.

Plan to be submitted via email to nicole.ranger@ontario.ca by August 12, 2016.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that resident #054 was protected from abuse by anyone and not neglected by the licensee or staff.

Under O. Reg. 79/10, s. 5 for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well being of one or more residents.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in

subsection 2 (1) of the Act, "physical abuse" means (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

On May 18 2016, an inspection began for a complaint inspection, an allegation of resident to resident abuse. Resident #054 was hit with a plastic object by resident #060.
Staff interviews and record review revealed that during the evening of an identified date in 2016, resident #054 was inside a specified area with other residents, when PSW #141 heard screaming and yelling in that area. Upon entering the area, PSW #141 reported he/she observed resident #060 hitting resident #054 with a plastic object. PSW #141 reported that he/she separated the residents and resident #060 continued to yell and scream at resident #054. Resident #054 sustained an injury to a part of his/her body.

During a family conference on an identified date, related to the incident, the home informed the family of resident #054 that the plastic object on the unit will be replaced with a very light plastic material and was ordered for replacement.

On May 19, 2016, the inspector observed yellow plastic objects on the identified unit from 1250 hours to 1500 hours in the t.v lounge area, with multiple residents in the t.v lounge and there was no indication for the objects' use at the time of the observation. Inspector spoke with registered staff #100 who observed the objects in the t.v lounge at 1500 hours and reported that the objects should not be there and immediately removed them.

On May 26, 2016, the inspector observed the plastic object in the dining room on the identified unit at 1027 hours. Inspector observed residents seated in the hallway along the dining room. Inspector spoke with registered staff #109 and inquired if there is any safety concerns the staff should be monitoring for resident #060 and resident #054. Registered staff #109 reported that the instructions he/she received is that if he/she sees the object around resident #060 they should remove it and redirect the resident. Inspector requested registered staff #109 to identify resident #060, and the registered staff identified resident #060 who was sitting at the window, near the dining room and within vicinity of the object. Inspector asked the registered staff if the object should be there as there was no indication for the object's use at the time of the observation. Registered staff #109 reported it should not be there and immediately removed the object.

During interviews with PSW #126, #141, housekeeping staff #160 and #169, the staff reported that there was a discrepancy as to whose responsibility it was to remove the plastic object when not in use.

The PSW staff reported that the housekeeping staff should remove the plastic object when no longer required, and the housekeeping staff reported that the PSW should also assist with removing the plastic object. Interview with PSW #141 reported that he/she was concerned about the use of the plastic object and resident safety after the incident and spoke with management about this issue. All staff interviewed reported that they were aware of the incident but reported that they did not receive any notification from management about the issue.

Interviews with the Director of Care (DOC) and Executive Director (ED) reveals that the home will replace the plastic object with a softer material. The ED and the DOC confirmed that the abuse had taken place and education is required to staff regarding the safety for the residents with the plastic objects on the unit. [s. 19. (1)]

(189)

2. 2. On May 18 2016, an inspection began for a complaint inspection, an allegation of resident to resident abuse. Resident #054 was punched by resident #061.

On an identified date, resident #054 was sitting in the dining room. Registered staff #163 reported that he/she was passing the dining room, when he/she observed resident #061 standing over resident #054. Resident #061 took his/her left hand and held resident #054 neck, then took his/her right hand and punched resident #054. Registered staff reported that he/she went to get another staff to assist to separate the residents. Registered staff #109 reported that this was the third incident involving resident #061 and they were having difficulty managing resident #061 behaviours.

Interviews with the Executive Director and the Director of Care confirmed that the abuse had taken place. [s. 19. (1)] (189)

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 : Oct 14, 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 27th day of July, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Slavica Vucko

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