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

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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
Dec 22, 2016; Jan 3, 2017	2016_467591_0010	026434-16	Resident Quality Inspection

Licensee/Titulaire de permis

TYNDALL NURSING HOME LIMITED
1060 EGLINTON AVENUE EAST MISSISSAUGA ON L4W 1K3

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

TYNDALL NURSING HOME
1060 EGLINTON AVENUE EAST MISSISSAUGA ON L4W 1K3

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

NATASHA JONES (591), DARIA TRZOS (561), HEATHER PRESTON (640), KATHLEEN MILLAR (527), MICHELLE WARRENER (107)

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): August 29, 20, 31, September 1, 2, 6, 7, 8, 9, 13, 14, 15, and 16.

The following Critical Incidents, Complaint and Follow-up Inspections were inspected concurrently with the Resident Quality Inspection (RQI).

The Critical Incidents included:

Log #008075-15 - related to a fall
Log #014201-15 - related to an alleged staff to resident abuse
Log #020398-15 - related to an alleged resident to resident abuse
Log #026769-15 - related to a fall with injury
Log #012419-16 - related to an alleged staff to resident abuse
Log #012808-16 - related to a fall
Log #016176-16 - related to an alleged resident to resident abuse
Log #018897-16 - related to an alleged resident to resident abuse

The Complaints included:
Log #018578-15 - related to resident care concerns
Log #023115-15 - related to a fall
Log #029461-15 - related to insufficient staffing
Log #035850-15 - related to resident care concerns
Log #007079-16 - related to insufficient staffing

The Follow-up Inspections included:
Log #010898-15 - related to plan of care
Log #010901-15 - related to abuse
Log #010955-15 - related to residents rights
Log #010957-15 - related to policy
Log #006060-16 - related to communication

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Resident Care Coordinator (RCC), the Continuous Quality Improvement (CQI) Risk Coordinator, the Resident Assessment Instrument (RAI) Coordinator, the Food Services Manager (FSM), the Recreation Manager, the Registered Dietitian (RD), the Recreation Coordinator, the Behavioural Support Ontario (BSO) staff, the Continence Lead, the cook, Nurse Managers (NMs), registered staff, physiotherapy assistants (PTAs), recreation aides, dietary aides, maintenance workers, housekeeping staff, personal support workers (PSWs), residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **26 WN(s)**
- **18 VPC(s)**
- **6 CO(s)**
- **1 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. 107. (3.1)	CO #008	2015_338147_0009	527
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #002	2015_338147_0009	527
O.Reg 79/10 s. 8. (1)	CO #010	2015_338147_0009	591

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

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

Findings/Faits saillants :

1. The licensee failed to ensure the resident was given the opportunity to participate fully in the development and implementation of their plan of care related to continence.

Record review revealed registered staff completed part of a bowel and bladder continence assessment when resident #143 was admitted to the home in 2016; however, the resident was not included in the assessment process or in the development of their plan of care related to continence. All questions on the assessment form that required resident input were blank. In an interview, the Continence Lead confirmed the continence assessments were completed on the night shift and therefore, the resident was not included in the assessment. The resident was cognitively well and would have been able to provide input into the assessment.
The licensee did not ensure the resident participated in the development and implementation of their plan of care related to continence. (107)

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

A) Observations by a Long Term Care Home (LTCH) Inspector of resident #093 on September 13, 14, and 15, 2016, between specified hours revealed staff did not assist

them to stand every two hours while up in their wheelchair.
A review of the resident's written plan of care, revised in a specified month in 2016, directed staff to remove the safety device and stand the resident up every two hours when they were in their chair.
In interviews on September 13 and 14, 2016, Person Support Workers (PSWs) #282 and #288 confirmed staff did not stand the resident up every two hours when they were in their chair. In an interview on September 14, 2016, the physiotherapy assistant (PTA) confirmed the expectation of staff to stand the resident up. In an interview on September 14, 2016, the Director of Care (DOC) and the Assistant Director of Care (ADOC) confirmed staff did not provide care as specified in the written plan of care for resident #093. (591)

B) Resident #123 had responsive behaviours, which involved resident #154 on two occasions in 2015 and 2016, and another resident in a specified month in 2016. The resident's clinical health record was reviewed and identified on the "Behavioural SBAR - Huddle Communication Tool", and on the written plans of care revised in specified months in 2015 and 2016, that one of the responsive behaviour mitigation strategies was that staff ensure resident #123 was not seated next to specified residents at any time. During this inspection on September 2, 3, and 17, 2016, resident #123 was observed seated between two specified residents in the lounge. When registered staff #276, #283 and PSW #287 were interviewed, they confirmed the resident was not to be seated next to the specified residents related to their responsive behaviours. The DOC and ADOC were interviewed and also confirmed the resident was not to be seated next to the specified residents to mitigate responsive behaviours. The home did not ensure the care set out in the plan of care was provided to resident #123 as specified in their written plan of care. (527)

C) Observations on September 7, 2016, revealed not all residents received the care set out in their written plans of care at snack pass:

i) Resident #134 had a written plan of care that directed staff to provide a pureed texture menu. The resident was provided two regular textured cookies. Pureed cookies were available on the snack cart; however, the resident was offered and accepted regular cookies. PSW staff had not referenced the diet list available on the snack cart.

ii) Resident #058 had a written plan of care that directed staff to provide honey consistency thickened fluids. The resident was given thin fluids.

iii) Residents #123 and #133 had written plans of care that directed staff to provide a diabetic diet. Both regular and diabetic drink crystals were available on the snack cart. The residents did not ask for regular crystals; however, were provided regular drink crystals. During an interview, the Registered Dietitian (RD) stated residents on diabetic diets were to receive diet drink crystals unless the resident asked for regular or it was identified in their written plan of care they were to have regular drink crystals.

iv) Residents #100, #054, and #079 had written plans of care that directed staff to provide a regular diet. It was observed that the residents had not asked for; however, were provided diet drink crystals.

v) Resident #086 had a written plan of care that directed staff to provide a pureed texture and nectar consistency thickened fluids. It was observed the resident was offered a pureed snack; however, was not offered a beverage at the snack pass. (107)

D) Observations on September 14, 2016, revealed not all residents received the care set out in their written plans of care at snack pass.

i) Resident #096 had a written plan of care that directed staff to provide nectar consistency thickened fluids. The resident had not asked for; however, was provided thin drink crystals. The staff providing the beverage was not aware of the resident's diet until clarified by a LTCH Inspector. The thin beverage was then removed and thickener was added. PSW #296 confirmed the resident required nectar consistency thickened fluids.

ii) Residents #090, #095, and #089 had written plans of care that directed staff to provide a diabetic diet. Both regular and diabetic drink crystals were available on the snack cart. The residents did not ask for regular crystals; however, were provided regular drink crystals. During an interview, the RD stated that residents on diabetic diets were to receive diet drink crystals unless the resident asked for regular or it was identified in their written plan of care that they were to have regular drink crystals.

iii) Residents #063 and #074 had written plans of care that directed staff to provide a diabetic diet. The residents had not asked for; however, were provided a coffee or tea with sugar added. Resident #074 had two sugars added to their tea. The RD confirmed that residents requiring diabetic menus were to be offered sweetener unless they specifically requested sugar or it was otherwise identified in their written plan of care. Resident #074 also required Lactaid milk; however, regular milk was provided in their tea. Lactose reduced milk was available on the snack cart.

Staff delivering snacks provided the name of each resident and confirmed to the LTCH Inspector what was given to each resident during the observed snack pass.
Compliance Order #001, issued in May 2015, required the home to provide training related to the procedures for snack provision and the home's, "Nourishment Cart" policy. Not all staff received the required training. 39 out of 80 (47.6 per cent) of staff attended the required training as confirmed by the Administrator. (107)

E) Observations of resident #088 throughout the course of the inspection revealed a safety device was attached from the resident's wheelchair to their clothing while they were in the chair. On September 7, 2016, a LTCH Inspector observed the resident get up from their wheelchair; however, the safety device was not attached to their clothing or the chair. PSW #266 assisted the resident back to the chair, retrieved the safety device from the resident's room, and attached it to the chair and resident.
A review of resident #088's clinical health record revealed they had a fall in July 2016, which resulted in an injury. A review of the resident's written plan of care, last revised July, 2016, indicated staff were to ensure the safety device was in place and were to respond promptly as indicated, and identified the resident as being a high risk for falls. In interviews on September 7 and 14, 2016, registered staff #259, and PSW #266 confirmed the safety device was not attached to resident #088, but should have been, as per their written plan of care. [s. 6. (7)]

3. The licensee failed to ensure the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A) Resident #061 was interviewed on September 8, 2016. The resident stated that they had difficulty communicating with the staff and there were no tools implemented in the home to assist them with communication. Furthermore, the resident stated the use of pictures/communication cards or gestures did not help them understand the staff in most cases.
A review of progress note in a specified month in 2016, indicated the home had reassessed the use of the picture board, identified that this strategy was ineffective and the resident was able to understand staff. The written plan of care was not revised after this assessment and no new interventions had been developed for resident #061.
The DOC confirmed the written plan of care was not updated for resident #061. (561)

B) Observations during the course of the inspection revealed resident #088 was not ambulatory and used a wheelchair with one staff assistance for mobility. The resident

was observed to be transferred from their bed to a chair with the assistance of two staff. The resident's altered skin integrity was observed to be healed. A review of the resident's clinical health record indicated the resident was seen in a clinic in a specified month in 2016, and the recommendation was the resident was wheelchair bound, but permitted to weight bear for transfers. The notes further indicated the home's physiotherapist (PT) conducted a post fall reassessment in a specified month in 2016, and determined the resident was unable to walk, but able to stand and transfer with the assistance of two staff.
A review of resident #088's most recent written plan of care provided several specific directions for the staff to follow.
In an interview during this inspection, the resident's family member confirmed resident #088 was ambulatory with a walker prior to a fall they sustained in a specified month in 2016, which resulted in an injury. PSW #266 and registered staff #259 in interviews on September 7, 2016, also confirmed the resident was ambulatory with a walker prior to the above mentioned fall, and currently used a wheelchair with one person to assist them for mobility, two persons to assist them with transfers from bed to chair and vice versa, and the resident had been given ambulation restrictions. PSW #266 and registered staff #259 stated the resident's altered skin integrity had healed no longer requiring treatment, and the resident had already been assessed by the PT and was no longer on identified restrictions.
Registered staff #259 in an interview on September 7, 2016, and the DOC and ADOC in an interview on September 8, 2016, confirmed resident #088's written plan of care was not revised when the resident's care needs changed or care set out in the plan was no longer necessary. (591)

C) Observations of resident #093 on September 13, 14, and 15, 2016, revealed they did not use an identified safety device while sitting in their wheelchair.
A review of the resident's most recent written plan of care, last revised in a specified month in 2016, directed the staff to apply an identified safety device when the resident was up in their wheelchair.
In an interview with PSW #282 on September 13, 2016, and interviews with PSW #288, and registered staff #250 on September 14, 2016, confirmed the resident did not like to use the safety device, and the resident had not used the safety device for several months. The registered staff further confirmed the safety device was no longer necessary when an alternative intervention was implemented to prevent the resident from falling.
In an interview, the DOC and ADOC confirmed resident #093's written plan of care was not updated when use of the safety device was no longer necessary. (591)

D) Resident #091 was interviewed on September 8, 2016. The resident stated they could not communicate with staff in the home. The resident was observed to have picture/communication cards. The resident stated that they could not read as a result of their medical condition and were unable to tell the message behind the pictures. The resident further confirmed the picture cards were not used by staff. PSW #273 that provided direct care to the resident in an interview indicated the picture/communication board was not used for the resident.
A review of the resident's written plan of care, last revised in a specified month in 2016, indicated several specific interventions were to be in place for the resident related to communication.
In an interview on September 9, 2016, the Nurse Manager (NM) confirmed the home had completed evaluations related to the use of the picture/communication boards for residents. The "Communication Evaluation" sheet indicated the use of picture/communication boards was effective for resident #091. The evaluation was not dated and neither the NM nor the Director or Care (DOC) could confirm when the evaluation was completed. In an interview on September 9, 2016, the DOC confirmed they were not aware the resident could not read, and the picture/communication board was not being used by staff or the resident, therefore an ineffective strategy for communication with resident #091. The DOC further confirmed the plan of care was not revised when resident #091's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents are given the opportunity to participate fully in the development and implementation of their plan of care related to continence; that the care set out in the plan of care is provided to the resident as specified in the plan; and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee failed to ensure strategies were developed and implemented to meet the needs of residents who could not communicate in the language or languages used in the home.

A) An order was issued for this non-compliance on May 2015, with a compliance date of July 2015. A Follow Up inspection was conducted in January 2016, and the report was issued in February 2016. The order was re-issued with the compliance date of March 2016.

B) The order re-issued in February 2016, ordered the home to provide training to staff on the use of available communication tools, strategies and interventions to meet the needs of residents who did not communicate in the language or languages used in the home. The home's training records were reviewed during this inspection and indicated the home had trained 73 per cent (%) of all staff in 2015, in a session titled "Communication: Barriers to Language, Cognition and Medical" which included strategies to communicate with residents, and an evaluation of the effectiveness of the communication strategies and use of picture boards. The training records also indicated the due date for this education was September 2016.
In interviews in September 2016, PSW #273 and registered staff #250 confirmed they had not attended the above mentioned communication training. The DOC in an interview also in September 2016, confirmed the home had not trained all staff in the home in 2015, and were still at 73% trained as of September 2016.

C) Residents #061 and #091 were interviewed during this inspection. Through interviews with the residents, staff, and review of their clinical health record, it was identified that the home continued to be in non-compliance with section 43 of the Long Term Care Homes Act (LTCHA).

i) During previous inspections, in April 2015, and January 2016, it was identified resident #061 was not able to understand the staff when gestures, words or facial expressions were employed as instructed by their written plan of care.
During the previous inspection in January 2016, it was identified that the home had incorporated a specified strategy to help with communication; however, they were proven to be ineffective.
During this inspection, resident #061 was interviewed. The resident confirmed they could not communicate with staff in the home and there were no tools implemented in the home to assist them with communication. The resident identified a medical condition that interfered with their ability to use the pictures/communication cards. Resident #061 verbalized feelings of loneliness, as they were unable to fully communicate their needs to staff in the home.
A review of a progress note in a specified month in 2016, indicated the home had reassessed the use of the picture board, had identified that this strategy was ineffective and the resident was able to understand staff. The most recent written plan of care was not updated to reflect the re-assessment.
PSW #273 and registered staff #250 that provided direct care to the resident were interviewed and stated they used gestures to communicate with resident #061 and the resident was able to understand.
The DOC confirmed the written plan of care should have been updated. There was no evidence that any other interventions or strategies were tried or implemented. The DOC stated the home had discussed purchasing an electronic device but that had not yet been implemented. The home could not provide documentation to confirm the discussion.

ii) During this inspection, resident #091 was interviewed. The resident confirmed they could not communicate with staff in the home. The resident was observed to have picture/communication cards; however, the resident stated they could no longer read as a result of a medical condition. The resident was unable to interpret the message behind the pictures, and confirmed the picture cards were not used by the staff. Furthermore, the resident verbalized there were no staff working in the home who they could communicate with. The resident verbalized feelings of loneliness and inability to fully enjoy and interact with other residents and staff during activities.
In an interview, PSW #273 that provided direct care to the resident confirmed the picture/communication board was not being used for the resident. The resident's clinical health records were reviewed and the most recent written plan of care provided several specified directions related to communication.
In an interview on September 9, 2016, the NM confirmed the home had completed

evaluations of the use of picture/communication boards for residents with language barriers. The "Communication Evaluation" sheet indicated the use of picture/communication boards were effective for resident #091. The evaluation was not dated and the NM could not recall when it was completed.
In an interview on September 9, 2016, the DOC confirmed they did not know when the evaluation was completed and further they were not aware resident #091's medical condition affected their ability to use the picture/communication board, nor were they aware the picture/communication board was not being used by staff or the resident. The DOC confirmed the strategies and interventions that had been implemented to facilitate communication with the resident should have been re-evaluated when they were no longer effective.
After the inspection was completed, another copy of the evaluation was sent from the home to a LTCH Inspector via email with a written date on the evaluation which was March 2016. [s. 43.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. As part of the organized program of maintenance services under clause 15(1)(c) of the Act, the licensee failed to ensure procedures and schedules were in place for routine and remedial maintenance.

The home's maintenance policies were revised in May 2016; however, the policies had not been implemented within the home and staff had not been trained on the new policies as of September 2016. The home’s policy, #FSM-C-10, titled "Preventative Maintenance Schedule ", directed the Director of Facility Services to complete a monthly preventative maintenance report and forward to the facility Administrator. Routine preventative maintenance audits were in place and documentation was reviewed confirming that the audits were conducted and scheduled. No schedules were in place for review to determine which tub or shower rooms, resident rooms and bathrooms were to receive the required repairs, particularly for walls, vanities, floors, baseboards and door trims.
The home's policy #FSM-C-122, titled "Maintenance Procedures ", identified that during audits, staff were to check to ensure that there were “no cracks, peeling arborite, stains or other damage on vanities; check for chips, stains, rust on sinks; faucets should be in good repair, open freely, no evidence of rust; floors should be checked for cracks, stains, paying particular attention to evidence of urine soaking under tiles and replace as needed; and tubs and shower stalls were to be checked for any cracks, chips or stains”.
The home's policy # FSM-C-120, titled "Painting ", directed staff to paint room(s) or areas per month as per outline for priority areas. Areas were to be inspected for “the need for repairs of any damaged walls prior to painting, and to replace and repair any baseboards following painting”.
Routine remedial maintenance was not consistently being completed in the home. The Administrator confirmed that the entire home was painted in June 2015, and additional painting was completed in three specified rooms in July 2016. A schedule was not established to continue routine painting as needed and as identified by the audits completed. Multiple rooms were identified as in need of painting during this inspection.
During the inspection, tours of the home were completed on August 30 and September 9, 2016, and the following areas of disrepair were identified:

i) Baseboards were missing or pulled out from the wall in eight specified rooms. On August 22, 2016, the maintenance request book noted baseboards coming off the walls in six specified rooms; however, a date for rectifying or addressing the issue was not identified.

ii) Washroom vanities had exposed particle board resulting in rough edges that would be difficult to clean and could pose safety concerns in three specified rooms. The vanity in one specified room had not been identified on the "Environmental Tracking Form - Replacement of Bathroom Counters & Sink updated July 2016" form, and the vanity in one specified room identified a re-check was required but no action was documented.

The second floor shower room had chips in the counter top edges, resulting in areas that were rough and not sealed and the vanity in one specified room was lifting.

iii) Walls/Ceilings/floors. The Administrator confirmed the home had been painted in 2015, and two specified rooms were re-painted in July 2016; however, a schedule for the remedial component of the maintenance program for all rooms was not in place. The maintenance request book included areas that required maintenance/painting on August 22, 2016, for three specified rooms and third floor east hallway; however, the work was not scheduled and had not been completed by the time of this inspection.
During the inspection four specified rooms were identified as requiring repair or painting (the whole home was not inspected). Painting was needed around almost all bathroom doors on the third floor as the paint was chipped and coming off. Paint on the 3rd floor linen room door was also flaking. The third floor shower room had some cracked or chipped wall tiles in corner by the wall heater, one specified room had a large divot in the new floor tile in the room entrance, and another specified room had two missing ceramic floor tiles at the entrance to the bathroom. In the fourth floor shower room the baseboard heater was rusty and the tiles in the shower area were cracked. In the third floor shower room the baseboard heater was severely dented. In the second floor shower room the floor had a split in it just before the transition into the shower area. In the second floor tub room, the flooring in the shower enclosure had splits in the flooring material (previously identified during inspections in April 2015, and January 2016), the cover had fallen off the baseboard heater, there was wall and tile damage just above the baseboards by tub and toilet areas, and apparent water damage on the ceiling (paint bubbled on ceiling above).

iv) Rust was noted around the sink drains in two specified rooms. A leaky faucet was noted in one specified room which wasn't identified in the maintenance book until September 8, 2016, when the LTCH Inspector inquired about it. The resident stated that it had been leaking for quite some time prior to that. The faucet was still leaking as of September 14, 2016.

v) Urine odours were noted in the washroom of one specified room creating an ongoing urine odour in the washroom that was present throughout the course of the inspection. It was suspected that urine may have seeped into a location within the bathroom that could not be cleaned.

vi) Handrails on both the second and third floor were in poor condition with rough areas and chipped sections and in some cases, covered with duct tape. The Administrator reported that plans were proposed to remove and replace the handrails but no specific

dates could be provided. [s. 90. (1) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: staff applied the physical device in accordance with any manufacturer's instructions.

Observations of resident #093 by a LTCH Inspector on September 13, and 14, 2016, at specified times, revealed the resident was secured with a safety device while sitting in their wheelchair. The LTCH Inspector was able to test the device and confirm that it was not being used appropriately.
In interviews on September 13, 2016, with PSW #282, and September 14, 2016, with PSW #288, and registered staff #250 confirmed the resident was sometimes able to release the safety device independently; however, most of the time they could not. In

interviews, PSW's #282, #288, and registered staff #250 did not know how to use the safety device appropriately to ensure the resident was safe, and further confirmed resident #093 was at risk.
A review of a document titled "Future - Orion III –Owner's Manual" provided direction for the user on how to use the safety device appropriately. A review of policy #CPME-10, titled "Restraints - Overview", indicated the safety device must be applied in strict accordance with manufacturer's specifications. A review of the home's 2015 and 2016 restraint training materials did not include safety related to the safety device use.
The safety device used for resident #093 was not applied in accordance with the manufacturer's instructions. [s. 110. (1) 1.]

2. The licensee failed to ensure the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act: that staff only apply the physical device that had been ordered or approved by a physician or registered nurse in the extended class.
Observations on September 14 and 15, 2016, revealed resident #148 was in a wheelchair which was reclined. Observations by a LTCH Inspector on September 14, 2016, revealed PSW #287 had tilted the resident back to a lying position in their wheelchair. The PSW in an interview at the time of the observation stated the wheelchair was used as a personal assistance services device (PASD) for the resident for comfort and repositioning, and further confirmed resident #148 could not get out of the tilt wheelchair independently if the chair was reclined. This was also confirmed by registered staff #263.
A review of the resident's clinical health record revealed an order for restraint was not obtained, and an assessment for the use of the wheelchair could not be located. This was confirmed by registered staff #263. A review of the resident's most recent written plan of care did not identify the use of the wheelchair as either a PASD or a restraint.
In an interview on September 15, 2016, the DOC and ADOC confirmed an order for the use of a restraint for resident #148 should have been obtained prior to use. [s. 110. (2) 1.]

Additional Required Actions:

CO # - 004, 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 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:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. 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:
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure training related to continence care and bowel management was provided to all staff that provided direct care to residents either annually or based on the staff's assessed training needs.

In an interview, the DOC confirmed not all direct care staff received the required training in 2015 or to date in 2016. An education session for direct care staff was held October 2015; however, only 44 out of 70 (62.8%) attended the education session. The education was focused on incontinence products and did not include education related to the home's continence program, policies and procedures, and assessments. [s. 221. (1) 3.]

2. The licensee failed to ensure training was provided to all staff who applied physical devices or who monitored residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.

In interviews on September 7, and 14, 2016, registered staff #259 and #263 confirmed they had not received restraint training in 2015 or 2016. In interviews on September 7, and 14, 2016, PSW's #266, #287, and #288 confirmed they had not received restraint training in 2015 or 2016. In an interview on September 15, 2016, the DOC confirmed 32 out of 95 (34%) of direct care staff completed the training session, titled "Falls Prevention Program and Least Restraint", offered April 2015. They further confirmed restraint training for 2016 had not yet been completed by all staff.
The licensee did not ensure all staff that provided direct care to residents received restraint training in 2015. [s. 221. (1) 5.]

3. The licensee failed to ensure for staff who applied PASD's or monitored residents with PASD's, training in the application, use and potential dangers of the PASD's.

A review of the 2015 and 2016 training materials did not include all of the legislated requirements related to PASD use. The DOC presented a draft of a policy titled "Personal Assistive Services Device – PASD's", and confirmed the draft had not yet been approved or presented to the staff.
In interviews on September 7 and 14, 2016:
- registered staff #259 confirmed tilt wheelchairs were used for comfort and positioning of residents, and also had restraining features,
- registered staff #250 was unsure whether a tilt wheelchair was a PASD or a restraint, and
- registered staff #263 stated they had been instructed not to recline residents in tilt wheelchairs as restraining of residents in the home was not permitted.
All of the above mentioned staff, including PSW's #266, #287, and #288, confirmed in interviews on September 7 and 14, 2016, they had not received PASD training in 2015, or 2016.
In an interview on September 15, 2016, the DOC confirmed 32 out of 95 (34%) of direct care staff completed the training session, titled "Falls Prevention Program and Least Restraint", offered April 2015.
The licensee did not ensure all staff that provided direct care received PASD training in 2015. [s. 221. (1) 6.]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure where the Regulation required 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 plan, policy, protocol, procedure, strategy or system was complied with.

A)The home's policy #SP-B-15, titled "Clinical Pathway", revised March 2016, directed if a resident had a new, changed or recurrent responsive behaviour, the charge nurse, NM, or designate would initiate a "Behavioural SBAR - Huddle" which would be documented on the communication tool. After reviewing resident #123's clinical record related to the responsive behaviours in a specified month in 2015, no "Behavioural SBAR - Huddle" was documented on the communication tool, and the documentation related to the responsive behaviour huddle was incomplete. The DOC, ADOC and Behavioural Supports Ontario (BSO) staff were interviewed and they were unable to identify the reason why the documentation and huddles did not occur, and/or why the huddle documentation in a specified month in 2015, was incomplete. The home did not ensure that staff complied with their "Clinical Pathway" policy related to responsive behaviours for resident #123. (527)

B) The home submitted a critical incident report to the MOHLTC Director in June 2015,

which indicated on a specific day in June 2015, PSW #266 reported to registered staff #250 altered skin integrity on resident #067. A review of the home's policy #CPM-F-20, titled "Skin and Wound Care Program Implementation", directed staff to conduct a head-to-toe assessment using the electronic tool in Point Click Care (PCC) for all residents whenever there was a change in health status that affected their skin integrity. The clinical health record was reviewed and a head-to-toe assessment was not completed. Registered staff #250 was interviewed and confirmed a head-to-toe assessment had not been completed. The primary registered staff #264 to whom the altered skin integrity was reported, was interviewed and confirmed no recollection of having completed a head-to-toe assessment. The DOC was interviewed and confirmed the "Skin and Wound Care Program Implementation" policy directed staff to complete a head-to-toe assessment, and further confirmed an assessment was not completed following the report of resident #067's altered skin integrity. The home did not ensure that staff complied with their "Skin and Wound Care Program Implementation" policy. (640)

C) In a specified month in 2015, a family member of resident #155 noticed altered skin integrity on the resident and immediately reported it to registered staff. The clinical health record was reviewed and neither an assessment of the altered skin integrity, nor a head-to-toe assessment was completed. The clinical health record identified altered skin integrity on the resident; however, the documentation did not include a description or an assessment of it. In an interview with registered staff #250, they stated the location of the altered skin integrity was not documented. The home's policy #CPM-F-20, titled "Skin and Wound Care Program Implementation", directed staff to conduct a head-to-toe assessment using the electronic tool in PCC for all residents whenever there was a change in their health status that affected their skin integrity. The DOC and registered staff #250 in interviews confirmed neither a head-to-toe assessment nor an assessment of the altered skin integrity was completed and registered staff were expected to complete an assessment of the altered skin integrity on each shift until it had subsided. The home did not ensure resident #155 received a skin assessment by a registered staff for their altered skin integrity, as per their "Skin and Wound Care Program Implementation" policy. (640)

D) The home's policy #DTY-A-60, titled "Hydration Assessment and Management ", directed all consumed fluids were documented, including fluids given with medications. In an interview, the DOC confirmed staff were expected to document fluids provided at the medication pass in the Point of Care (POC) system. Registered staff #263 confirmed in an interview that fluids consumed during medication passes were required to be entered into the computerized documentation system; however, often were not. In an interview,

registered staff #296 stated that fluids consumed during medication pass were never included in the documentation system and were over and above what was recorded in the documentation system. A review of the food and fluid intake records for a specified two month period in 2015, for residents #088 and #093 did not routinely include fluids provided during delivery of medications. Both residents were routinely recorded as not meeting their hydration requirement. The home did not ensure staff complied with their "Hydration Assessment and Management" policy. [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 where the 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 plan, policy, protocol, procedure, strategy or system is complied with,, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the written policy to minimize the restraining of residents was complied with.

The following home policies were reviewed:
- #CPM-E-10, titled "Restraints- Overview"
- #CPM-E-20, titled "Restraints- Reduction Program"
- #CPM-E-30, titled "Restraints- implementation"

Policy #CPM-E-20 directed to evaluate residents for appropriateness of restraining using the "Least Restraint Initial Assessment" on Point Click Care (PCC); determine the rationale for the restraint application, note the reason(s) including how the restraint would be monitored and how reduction of use would be attempted, then ensure they were included in the residents' plan of care; ensure a physician's order was obtained; schedule re-evaluation of the restraint use; repeat the process monthly as part of the home's Continuous Quality Improvement Plan.
Observations during the course of the inspection revealed resident #148 was in a wheelchair. Observations on September 14, 2016, revealed PSW #287 tilted the resident back to a lying position in their wheelchair.
In interviews, PSW #287 and registered staff #263 confirmed the resident could not get out of the wheelchair when the chair was reclined, without assistance. A review of resident #148's clinical health records revealed the "Least Restraint Initial Assessment" was not completed and no assessment for the use of the tilt wheelchair could be located. This was confirmed by registered staff #263 in an interview on September 14, 2016. A review of the resident's most recent written plan of care, last revised July 2016, did not identify the use of the wheelchair as either a PASD or a restraint.
In an interview on September 15, 2016, the DOC and ADOC confirmed the home's policy to minimize the restraining of residents was not complied with. [s. 29. (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 the written policy to minimize the restraining of residents is complied with,, 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 failed to ensure the Continence Care and Bowel Management program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The Continence Lead and DOC confirmed there had not been an evaluation of the Continence Care and Bowel Management program for the year 2015, or to date in 2016.

[s. 30. (1) 3.]

2. The licensee failed to ensure a written record was kept related to a program evaluation that included 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.

A) The licensee completed a MOHLTC "Skin and Wound Care Inspection Protocol" as their 2015 annual skin and wound care program evaluation. The document included the date of the evaluation and the names of the persons who participated in the evaluation; however, there was no summary of changes made to the program and no associated dates of any changes implemented. In an interview, the Administrator confirmed there was no summary of changes or associated dates included in the 2015 skin and wound care program evaluation.

B) The licensee completed a MOHLTC "Responsive Behaviour Inspection Protocol" as their 2015 annual responsive behaviour program evaluation. The document included the date of the evaluation and the names of the persons who participated in the evaluation; however, there was no summary of changes made to the program and no associated dates of any changes implemented. In an interview, the Administrator confirmed there was no summary of changes or associated dates included in the 2015 responsive behaviours program evaluation. [s. 30. (1) 4.]

3. The licensee failed to ensure 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 the clinical health records revealed resident #123 had a significant history of specified behaviours between specified months in 2015. A strategy was identified in the behaviour huddle and interdisciplinary discussions. The home's policy #SP-B-10, titled "Responsive Behaviours Program Overview", identified an intervention to implement with residents exhibiting behaviours. The resident's written plan of care indicated the resident's related programs and their participation; however, the participation and response to the strategy were inconsistently documented. A review of the clinical health record revealed that there was no documentation of the resident’s participation and responses to this strategy for management of the behaviours for 6 days in a specified month in 2015; for 11 days in another specified month 2015; and 10 days in another specified month in 2015. The Behavioural Supports Ontario (BSO) staff, the DOC and

the Recreation Manager, were interviewed on September 14, 2016, and indicated that they implemented a specific intervention as one of the strategies to manage the resident's behaviours. They also indicated that the resident sometimes refused the intervention and did not know what was done to improve on the intervention. The DOC and a specific Manager confirmed that selected staff and PSWs were expected to document the resident's participation and response to the intervention.
The home did not ensure resident #123's responses to interventions were documented in their clinical health record. [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 the Continence Care and Bowel Management program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and that a written record is kept relating to a program evaluation 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,, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee failed to ensure a resident may be restrained by a physical device as described in paragraph 3 of subsection 30(1) if the restraining of the resident was included in the resident's plan of care.

Observations during the inspection revealed resident #148 was in a wheelchair. Observations on September 14, 2016, revealed PSW #287 tilted the resident back to a lying position in their wheelchair.
In an interview on the day of the above mentioned observation, PSW #287 stated the resident had a history of falls, and they would attempt to get out of the wheelchair on their own without assistance. The PSW confirmed they tilted the wheelchair back so resident #148 could not get out and fall, while they were unsupervised. The PSW further confirmed the resident could not get out of the chair independently unless the wheelchair was in an upright position. In an interview on September 14, 2016, registered staff #263 stated staff were not permitted to recline residents in tilt wheelchairs as it would have a restraining effect, and further confirmed resident #148 could not get out of their wheelchair independently when it was reclined.
A review of resident #148's most recent written plan of care did not identify their use of the wheelchair. A review of the resident's clinical health record did not include a restraint or PASD assessment.
In an interview on September 15, 2016, the DOC and ADOC confirmed the wheelchair should have been identified as a restraint in resident #148's written plan of care. [s. 31. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a resident may be restrained by a physical device as described in paragraph 3 of subsection 30(1) if the restraining of the resident is included in the resident's plan of care,, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Observations of resident #088 throughout the course of the inspection revealed the resident used a wheelchair for mobility.
A review of the resident's most recent written plan of care, did not identify the wheelchair as a PASD. A review of the residents clinical health record did not include a PASD assessment. In interviews on September 7, 2016, registered staff #259 and PSW #266 confirmed the wheelchair was used for comfort and positioning for resident #088, and the resident was able to get out of the chair without assistance. Registered staff #259 further confirmed the wheelchair was not included in the resident's written plan of care, but should have been. In an interview on September 8, 2016, the DOC and ADOC identified the wheelchair used for resident #088 was a PASD and should have been included in the resident's written plan of care. [s. 33. (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 a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care,, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

A) Resident #110 had a witnessed fall in a specified month in 2016. The resident's clinical health record was reviewed and the written plan of care identified the resident required two persons and a mechanical device to assist them with transfers. On the day of the resident's fall, the resident was transferred with a mechanical device by PSW #284 without the assistance of a second staff. As a result, the resident fell. The resident was assessed immediately after the incident and there was no injury identified until days later. The staff then identified the resident had altered skin integrity with discomfort as a result of the fall. The DOC and the ADOC were interviewed and confirmed the resident was transferred unsafely with the assistance of one person instead of two, and the wrong type of mechanical device was used during the transfer resulting in the fall. The staff did not use safe transferring techniques and equipment when transferring resident #110.

B) Resident #152 had a fall in a specified month in 2015; however, the home was not aware that the resident had a fall until several days later. PSW #291 had originally identified to the home in an interview that the resident was found with altered skin integrity. The home interviewed PSW #291 again, and the PSW admitted they had repositioned the resident independently and the resident fell. In addition, PSW #291 identified they had independently lifted the resident off the floor without the use of a mechanical device. The resident was cognitively impaired and the PSW identified the resident had altered skin integrity after the fall. The clinical health record and the home's investigative notes were reviewed, which confirmed the chronology of the incident. The written plan of care indicated the resident required two staff to provide extensive assistance for bed mobility. The written plan of care also identified that the resident was at high risk for falls and two staff were required to use a mechanical device for all transfers. The DOC and ADOC were interviewed and confirmed the PSW did not follow the written plan of care to ensure safe transferring and positioning of the resident, which resulted in the resident falling. The home did not ensure resident #152 was safely transferred and positioned. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents,, to be implemented voluntarily.

WN #12: 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,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the Continence and Bowel Management program provided for an annual resident satisfaction evaluation of resident's 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 were negotiated or renegotiated.

In an interview, the DOC and the Continence Lead confirmed an annual resident satisfaction evaluation of continence care products was not completed for 2015 or 2016. [s. 51. (1) 5.]

2. The licensee failed to ensure each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted, using a clinically appropriate assessment instrument that was specifically designed for the assessment of incontinence.

A) A review of the clinical health record indicated resident #024 had a decline in bowel continence from continent to usually continent identified in a 2016 Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment coding. The home's policy #CPM-B-20, titled "Bowel and Bladder Continence Care Program Implementation", directed staff to complete a continence assessment using the point click care (PCC) assessment forms when there was a change in the resident's continence over the past 90 days identified in the RAI-MDS assessment. The Continence Lead in an interview stated the new policies from February 2016, had not yet been fully implemented with staff education related to the completion of assessments when there were changes to the resident's continence level after admission to the home. The PCC continence assessment identified by the home's above mentioned policy as their clinically appropriate assessment instrument, was not completed for resident #024. (107)

B) A review of the clinical health record indicated resident #143 had part of a continence assessment completed on admission in a specified month in 2016; however, the assessment did not include an assessment of the type of incontinence and potential to restore function. The resident then had a decline in bladder continence identified in a specified month in 2016, RAI-MDS assessment coding. A PCC continence assessment was not completed, using the clinically appropriate assessment instrument specifically designed for assessment of incontinence as per the home's policy. The Resident Assessment Protocol (RAP) also did not address the decline in the resident's continence and an assessment of the resident's continence decline was not completed. The home's policy #CPM-B-20, titled "Bowel and Bladder Continence Care Program Implementation", directed staff to complete a continence assessment using the PCC assessment forms when there was a change in the resident's continence over the past 90 days identified in the RAI-MDS assessment. In an interview, the Continence Lead stated newly developed policies from February 2016, had not yet been fully implemented with staff education

related to the completion of assessments when there were changes to the resident's continence level after admission to the home. The Continence Lead further confirmed resident #143's decline in continence was not assessed and their written plan of care did not include revised strategies related to their level of continence. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the Continence and Bowel Management program provides for an annual resident satisfaction evaluation of resident's 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; and each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and where the condition or circumstances of the resident require, an assessment is conducted, using a clinically appropriate assessment instrument that is specifically designed for the assessment of incontinence,, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure, for each resident demonstrating responsive behaviours, (a) the behaviour triggers for the resident were identified, where possible, (b) strategies were developed and implemented to respond to those behaviours, where possible; and (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A) A review of the clinical health record indicated resident #123 was cognitively impaired and demonstrated responsive behaviours during a specified period in 2015. There were six incidents where resident #123 exhibited behaviours which involved other cognitively impaired identified residents. The resident's most recent written plan of care identified the resident's responsive behaviour trigger. The documentation of external consultations with the psychogeriatric physicians and team, and the home's documentation of responsive behaviour huddles with the clinical team were reviewed and identified recommendations. Resident #123's written plan of care did not identify any strategies or interventions that were developed to respond to the resident's responsive behaviours. There was no consistent documentation of the resident's responses to interventions implemented.
The DOC, ADOC and BSO staff were interviewed on September 14, 2016, and were unable to provide a written plan of care or documentation to support that strategies were developed, implemented and that the resident's responses to the interventions were documented consistently.
The home did not ensure that resident #123 had documented strategies developed and implemented to respond to their behaviours, nor did they ensure there was consistent documentation of the resident's responses to the interventions. (527)

B) A review of the clinical health records indicated in a specified month in 2015, a family member of resident #155 reported to registered staff #150, an area of altered skin integrity on the resident. In an interview, registered staff #150 and PSW #173, the resident's primary care providers, confirmed that the resident frequently exhibited specific behaviours. Registered staff #159 obtained consent from the resident's SDM for a strategy to implement related to the resident's behaviours. The DOC and ADOC were interviewed and confirmed the trigger of the responsive behaviour for resident #155 was identified, a strategy was developed with the SDM; however, the strategy was not implemented. The resident's written plan of care, revised in a specified month in 2015, did not include the developed strategies to manage the responsive behaviours exhibited by resident #155. [s. 53. (4) (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, for each resident demonstrating responsive behaviours, (a) the behaviour triggers for the resident are identified, where possible, (b) strategies are developed and implemented to respond to those behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented,, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure the home's hydration program included the development and implementation, in consultation with a registered dietitian who was a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration.

The home's policy #DTY-A-60, titled "Hydration Assessment and Management ", did not include the implementation of interventions to mitigate and manage risks related to hydration. The home's Registered Dietitian (RD) confirmed they were not involved in the development of the hydration policy and they did not follow some sections of the home's policy due to risks not being identified or addressed in a prompt manner. The policy directed the RD to create a list of residents who consistently consumed 50% or less of their assessed fluid requirements and to post the list at the nursing units for staff reference. Registered staff were not to make a referral to the RD for those residents unless they had a significant change in fluid intake from the 50% or less. The policy did not reflect ongoing interventions to meet the resident's hydration needs; only that staff were to document in the resident's chart the ongoing failure to meet the resident's fluid needs with no further referrals to the RD. The policy also reflected an extended time frame for assessment of poor hydration and the involvement of the RD (may be up to 14 days) to address ongoing poor hydration. [s. 68. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home's hydration program includes the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration,, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the home's menu cycle included menus for therapeutic (modified diabetic) and texture modified diets (minced) for snacks.

Observations revealed therapeutic extension menus were not available for staff to reference during the snack service on September 7 and 14, 2016. Not all staff were consistent in their approach for diabetic menus and for minced textured items. A planned therapeutic extension menu was available from the Food Services Manager (FSM) when requested; however, staff actions differed from the planned menu for residents who required diabetic menus and minced texture diets. For residents who required modified diabetic menus, staff often provided multiple cookies, regular versus diet juice, and sugar versus sweetener in resident's hot beverages without the residents request for these items. The planned diabetic menu included one cookie and diet drinks for all residents regardless of whether they required calorie restriction or had a diet order for high energy items. Some staff provided cookies of regular texture and some located softer cookies, and refused to provide the cookies on the menu or they provided cookies that were almost of a pureed texture. Direction was not available to staff in what to serve residents for each diet and texture. [s. 71. (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 the home's menu cycle includes menus for therapeutic (modified diabetic) and texture modified diets (minced) for snacks,, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

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

s. 72. (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure there was an organized food production system in the home that included standardized recipes and production sheets for all menus.

Observations revealed standardized recipes and production sheets were not in place to direct staff in the consistent preparation and service of menu items when menu changes occurred. Both the FSM and the Cook confirmed recipes, production sheets, and therapeutic extension menus were not revised to reflect menu changes. A review of the recipes and production sheets did not reflect the actual menu items prepared and served by staff on four specified days in 2016, which resulted in items prepared that differed in nutritional value from the planned menu, reduced variety of items being served, and inconsistent portion sizes offered to residents. [s. 72. (2) (c)]

2. The licensee failed to ensure all menu items were prepared according to the planned menu.

Observations at the lunch meal on August 29, 2016, revealed the planned therapeutic extension menu included beef barley soup, cheese ravioli in rose sauce, garlic bread, zucchini medley, and cantaloupe or a turkey sandwich on rye bread, tossed salad or lemon buttermilk cake. The posted menu included vegetable soup, pasta with rose sauce, garlic bread, zucchini medley, and cantaloupe or a turkey sandwich on rye bread, tossed salad and citrus orange cake. Macaroni and cheese was prepared and served to residents, minced peaches or pureed fruit cocktail was served instead of the cantaloupe for the texture modified menus and the turkey sandwich was served on whole wheat bread and not rye bread. Pureed bread was also not prepared and served with the turkey for the pureed turkey sandwich. The Nurse Manager (NM) in an interview, confirmed that the beef was not thawed enough for the soup so vegetable soup was substituted, rye bread had not been ordered so whole wheat bread was substituted, macaroni and cheese had been substituted for the pasta and rose sauce as the pasta did not contain a protein choice, and the lemon buttermilk cake was not on the home's order guide so citrus orange cake was substituted. Rationale for the substitution of desserts was not provided to the LTCH Inspector.
Observations at the lunch meal on September 2, 2016, revealed the planned therapeutic extension menu directed staff to prepare minestrone soup, pork tourtiere, bread, broccoli, and mango, or French toast, Greek yogurt, warm fruit compote, citrus orange cake. Hot dogs, hamburgers, salad or corn on the cob was served. The Cook, in an interview, stated there was a weekly barbeque and hot dogs and hamburgers were served for the barbeque weekly. Therapeutic extension menus were not updated to reflect the changes to the menu and direction was not available for staff preparing the barbeque. The Cook stated hamburgers were already planned on the menu for the lunch meal Wednesday August 31, 2016, so the Friday and Wednesday menus were changed. Staff then substituted beef stew for the French toast and Greek yogurt at the August 31, 2016, meal. The menu had not been revised to reflect the change and the substitution resulted in reduced variety on the menu (beef burgundy was served for dinner the night before). The posted menu for August 31, 2016, also stated that citrus orange cake was to be served for the dessert; however, cake had been served at the lunch meal August 29, 2016. Observations at the lunch meal on September 7, 2016, revealed the planned menu required a coleslaw vinaigrette. The Cook, in an interview, confirmed a creamy coleslaw was prepared and that the recipe had not been consulted prior to making the coleslaw. The posted menus were not always consistent with what was actually served to residents, and some of the menu changes resulted in reduced variety on the menu. [s.72. (2) (d)]

3. The licensee failed to ensure menu substitutions were documented on the production sheet.

The home's policy #DTY-B-60, titled "Menu Planning ", directed staff to document menu substitutions on the menus and production sheet and identified that all changes to the menu were to be posted prior to the meal preparation. The policy also directed staff to document the reason for the change on the back of the menu posted in the kitchen. Observations revealed numerous menu changes occurred on August 29, 31, September 2, and 7, 2016; however, the menu changes were not documented on the production sheet and a system to document and monitor menu changes was not in place. The home kept a copy of the revised posted menu; however, the posted menu did not identify what was revised on the menu or why the substitutions occurred. In an interview, the FSM confirmed the home did not document menu substitutions on their production sheets. A review of the production sheets revealed they did not reflect the actual menu items prepared and served by staff on August 29, 31, September 2, and 7, 2016, which resulted in items prepared that differed in nutritional value from the planned menu, reduced variety of items served, and inconsistent portion sizes offered to residents. [s.72. (2) (g)]

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

Observations at the lunch meal August 29, 2016, revealed:

A)PSW’s who assisted four specified residents, mixed the residents' food together on the spoon or plate without the consent of the resident, which resulted in reduced taste and appearance of the meal.

i) Resident #126 had not asked for the pureed items to be mixed together and did not have a written plan of care in place that directed staff to mix the resident's food items at meals. PSW #255, who assisted the resident with eating, stated they mixed the food for most of the residents as many of the residents didn't like the vegetables and when the PSW mixed the foods the residents
didn't know what it was and would eat it.

ii). Resident #117 had not asked for the pureed food items to be mixed together and did not have a written plan of care in place that directed staff to mix the resident's food items

at meals. In an interview, PSW #257, who assisted the resident with eating, stated the resident did not eat well and they wanted to get more of the items into the resident at one time.

iii) Resident #128 had not asked for the minced items to be mixed together at the meal and did not have a written plan of care in place that directed staff to mix the resident's food items at meals. In an interview, PSW #257, who assisted the resident with eating, stated there was no particular reason they mixed the resident's food together.

iv) Resident #144 had not asked for the pureed items to be mixed together and did not have a written plan of care in place that directed staff to mix the resident's food items at meals. In an interview, PSW #256, who assisted the resident with eating, stated there was no particular reason they mixed the resident's food together. In an interview, the FSM confirmed staff should not mix texture modified foods together without the consent of the resident unless it was specifically indicated in the resident's written plan of care.

B) Not all food was served with methods that preserved nutritive value, appearance and food quality. Portions served to residents were often less than the planned menu at the observed lunch meal August 29, 2016, which resulted in reduced nutritive value of the meal.

i) The planned menu required a six ounce (oz) portion of pasta - a three oz portion was served to residents (#10 scoop) for all diet textures (regular, minced, and pureed).

ii) The planned menu required a four oz portion of zucchini - a three oz portion was served to residents receiving a regular texture menu (#10 scoop).

iii) The planned menu required four crackers to be offered to residents - residents were not offered crackers with their soup.

iv) The planned menu required a three oz portion of pureed turkey and a two and two thirds oz portion of pureed rye bread. A three oz portion of pureed turkey was served to residents (no bread).

v) The planned menu required a four oz portion of salad - residents were offered a small portion (tongs used - less than four oz). [s. 72. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is an organized food production system in the home that includes standardized recipes and production sheets for all menus; all menu items are prepared according to the planned menu; menu substitutions are documented on the production sheet; and all food and fluids in the production system are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality,, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.

A review of the home's policy #DTY-B-55, titled "Meal Service Temperature Standard", directed dietary aides to take the temperature of each menu item for all diet types and textures to ensure the item met the standard temperature range for food safety and referenced the "Meal Service Daily Temperature Record" where staff were to record the food temperatures.
At the observed lunch meal August 29, 2016, food temperatures were not taken or recorded for both meal sittings on the fourth floor (exception was soup temperatures which were recorded at the beginning of the first meal service for both the first and second meal sitting monitoring records).
In an interview, the FSM confirmed temperatures were required to be taken prior to meal service for both meal sittings and confirmed the forms for August 29, 2016, were blank (with the exception of the soup temperature). Resident #115 stated their meal was not hot enough, when interviewed by the LTCH Inspector during the observed lunch meal. Temperatures of the meal had not been taken or recorded prior to service to the residents. [s. 73. (1) 6.]

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 food and fluids are served at a temperature that is both safe and palatable to the residents,, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. As part of the organized program of housekeeping services under clause 15(1)(a) of the Act, the licensee failed to ensure procedures were developed and implemented for cleaning of the home, including, resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

The home's policy #FSM-AA-15, titled "Daily Resident Room Cleaning", directed staff to clean rooms daily, and to check privacy curtains for visible soiling and complete a maintenance work order if required. The home's policy #FSM-AC-125, titled "Privacy Curtains and Draperies", directed staff to inspect curtains during daily cleaning for stains, and to notify maintenance and send the curtains to laundry if required. The home's policy #FSM-AA-25, titled "Deep Cleaning of Resident Rooms", directed staff to thoroughly clean into corners and baseboards, dust and clean all air diffusers and grates in the room.

The following observations were made throughout the inspection and some were specifically observed on August 30, and September 9, 2016:

i) Dirty flooring was observed in two specified rooms. In a specified room, black areas were noted around the newly replaced floor tiles and under the beds (from bed legs). In room #416, after the floor was mopped, the floor still appeared dirty around the doorways. Third floor nursing station was very discoloured and appeared dirty with wax buildup.
In an interview, the Administrator confirmed the floors had been waxed prior to thorough cleaning (sealing in the dirt) and the home's policy for routine stripping and waxing had

not been followed.

ii) Soiled privacy curtains were noted in two specified rooms for the duration of the inspection. The maintenance log book was reviewed and there were no maintenance requests made for cleaning/replacement of the privacy curtains in these rooms.

iii) Shower/tub rooms on all floors were noted to have a number of sanitation issues. The fourth floor shower room was noted to have plastic corner protectors which appeared discoloured (dirty) and mould-like growth was noted on the grout in the shower area. The tub had dead insects, hair and a k-basin in it. The third floor shower commode appeared soiled and had hair on it (chair was dry and was not awaiting cleaning). The second floor shower room floor appeared dirty. The second floor main tub/shower room had mould-like growth in the caulking between tiles in the shower enclosure and beside the toilet, dirty corner protectors and a dirty floor around the shower drain.

iv) The exhaust vent on the bathroom ceiling in a specified room was pulled away from the ceiling and covered in a thick layer of dust. [s. 87. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure procedures are developed and implemented for cleaning of the home, including, resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces,, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee failed to ensure the home's written policy under section 29 of the Act dealt with how consent to the use of physical devices as set out in section 31 of the Act and the use of PASD's as set out in section 33 of the Act were to be obtained and documented.

The following policies were reviewed:
-#CPM-E-10, titled "Restraints - Overview"
-#CPM-E-20, titled "Restraints - Reduction Program"
-#CPM-E-30, titled "Restraints – Implementation"

The above mentioned policies did not include procedures related to the use of PASD's.
In an interview, registered staff #259 confirmed that resident #088 used a specified wheelchair for comfort and positioning, that the chair had restraining features when tilted back to a certain degree; however, consent was not obtained for its use. The staff further confirmed the home obtained consent for restraint use, but not for PASD use. In an interview, registered staff #250 was unsure whether the specified wheelchair was a PASD or a restraint, and confirmed that consents were not obtained for PASD use.
In an interview, registered staff #263 stated that they had had been instructed not to recline the residents in wheelchairs too far back, or it would be considered a restraint and restraining in the home was not permitted. The staff stated they believed there was a standing order for resident PASD use, therefore consent was not required.
In an interview, the DOC and ADOC stated the specified wheelchairs were not considered restraints. They further confirmed obtaining consent for PASD use was not the home's practice; however, they were in the process of correcting the practice by identifying all specified wheel chairs with a sign attached to the chair, and obtaining consents for their use to be included in the resident's clinical health records. The posting of signage on some of the
wheelchairs throughout the home was observed. The DOC presented a draft of a policy titled "Personal Assistive Services Device – PASD's", and confirmed the draft had not yet been approved or presented to staff.
The home's policies did not include how to obtain or document consent for PASD use with residents. [s. 109. (e)]

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 the home's written policy under section 29 of the Act deals with how consent to the use of physical devices as set out in section 31 of the Act and the use of PASD's as set out in section 33 of the Act is to be obtained and documented,, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act was undertaken on a monthly basis.

A review of the home's documents revealed a monthly analysis of the restraining of residents by use of a physical device was not completed. This was confirmed in interviews on September 15, 2016, with the Administrator, DOC, and ADOC. [s. 113. (a)]

2. The licensee failed to ensure at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvement were required to minimize restraining and to ensure that any restraining that was necessary was done in accordance with the Act and this regulation. A review of the home's documents revealed no annual evaluation to determine the effectiveness of the licensee's policy, what changes and/or improvements were required to minimize restraining, and the assurance any restraining that was necessary was done in accordance with the legislation. This was confirmed in interviews on September 15, 2016, with the Administrator, DOC, and ADOC. [s. 113. (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 an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis; at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvement are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this regulation,, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure, (a) drugs were stored in an area or a medication cart, (iv) that complied with the manufacturer??s instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting).

The home's policy #IC-F-40, titled "Vaccine Transportation and Storage", directed staff to return all expired vaccines and unused vials to the designated Public Health location in an insulated vaccine carry container. On September 7, 2016, a LTCH Inspector observed the vaccine fridge and identified 20 ampoules of Pneumococcal 13-Valent Conjugate vaccine that expired June 2016. The manufacturer's instructions identified that the vaccine was not to be used when expired. The DOC and ADOC were interviewed and confirmed the expired vaccines were expected to be removed and returned to Public Health as per the home's policy. The staff did not comply with their "Vaccine Transportation and Storage" policy and procedures or the manufacturer's instructions for expired drugs. [s. 129. (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 drugs are stored in an area or a medication cart that complies with the manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting),, to be implemented voluntarily.

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure steps were taken to ensure the security of the drug supply, including the following: 1. All areas where drugs are stored shall be kept locked at all times, when not in use.

A) The home's policy # NAM-G-05, titled "Administration of Medications", directed that staff should not leave the medication cart unattended unless locked, and the medication cart should be kept in visual contact during medication passes.

i) Observations on September 6, 2016, at 1300 hours (hrs), revealed the medication cart and the narcotic/controlled substances bin were unlocked and unattended on the 4th floor of the home. At the time the medication cart was found unlocked, there were numerous residents observed lined up in both the East and West wing and in the lounge beside where the unlocked medication cart was located. There were also several residents observed wondering in the hallway where the unlocked medication cart was located.

ii) Observations on September 7, 2016, at 1645h revealed the medication carts for 3 East, and 3 West, were unlocked and not visible to the registered staff. At the time the medication cart was found unlocked, there were numerous residents observed lined up in both the East and West wing and in the lounge beside where the medication cart was located. There were also several residents observed wondering in the hallway where the unlocked medication cart was located. Registered staff #270 on the 4th floor and registered staff #261 on the 3rd floor were interviewed and stated the medication carts should not have been left unlocked or unattended during their medication pass. The registered staff identified they did not follow the home's policies and procedures related to safe medication storage, and identified the risk to residents. The DOC was interviewed and confirmed the medication carts should be locked at all times when not in use and should not be left unattended during the medication pass by the registered staff. In an interview, the DOC confirmed registered staff #261 and #270 did not comply with the home's medication policy. The home did not ensure drugs stored in all areas of the home were kept locked at all times when not in use. [s. 130. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure steps are taken to ensure the security of the drug supply, including the following: 1. All areas where drugs are stored shall be kept locked at all times, when not in use,, to be implemented voluntarily.

WN #23: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure the following rights of residents were fully respected and promoted: 8) Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

Observations during the initial tour of the home on August 29, 2016, at 1100h, revealed resident #090's bedroom door was open, the resident had just finished toileting and the resident was exposed. The resident was interviewed and stated they felt embarrassed and they preferred the door to be closed when the nurses provided care to them. PSWs #274 and #275 were interviewed and identified they did not close the resident's door to ensure their privacy while they provided care to the resident. Registered staff #250 was interviewed and confirmed that the staff were expected to provide privacy to residents when they provided care and/or treatment. The home did not ensure that resident #090 was afforded privacy while staff provided their care. [s. 3. (1) 8.]

WN #24: 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 failed to report to the Director the results of every investigation undertaken under clause (1)(a) and every action taken under clause (1)(b).

An allegation of abuse/neglect from resident #024 was reported to the MOHLTC Director in a specified month in 2016. The report stated that an investigation had been initiated and follow up would occur once the staff member returned. No further updates were provided to the MOHLTC Director that indicated the outcome of the investigation or any long term actions planned to correct the situation and prevent recurrence. During an interview with resident #024 on September 15, 2016, the resident stated the concerns had not been resolved and remained ongoing. The Administrator confirmed the results of the alleged abuse/neglect investigation had not been submitted to the MOHLTC Director once the investigation had been completed. [s. 23. (2)]

WN #25: 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:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure a plan of care was based on, at a minimum, interdisciplinary assessment of the resident's continence, including bladder and bowel elimination.

A review of resident #024's clinical health record indicated their most recent written plan of care was not based on the interdisciplinary RAI-MDS and RAP assessments of the resident's continence. Coding for the RAI-MDS assessment completed in a specified month in 2016, identified the resident's continent status. Information on the resident's written plan of care identified a different continence status from their RAI-MDS assessment and another section of the resident's written plan of care identified yet another continence status. Information was also inconsistent on the assessments completed in a specified month in 2016. Coding for the RAI-MDS assessment identified the resident was frequently incontinent of bladder and usually continent of bowels. The resident's written plan of care identified the resident was incontinent of bowels with no control and another section of the written plan of care identified the resident was occasionally incontinent of both bladder and bowels. [s. 26. (3) 8.]

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The licensee failed to ensure drugs obtained for use in the home, except drugs obtained for any emergency drug supply, were obtained based on resident usage, and that no more than a three-month supply was kept in the home at any time.

Observations on September 6 and 7, 2016, revealed a supply of government stock drugs located in the medication rooms on the 2nd, 3rd and 4th floors of the home. In addition, there was a supply of government stock drugs in a storage room on the 3rd floor. The home's "Resident Usage" report, "Non-prescription drug ordering" forms, and "Government stock supply analysis" dated September 13, 2016, documents were reviewed and indicated the home had an eight month supply of drugs in the home at any given time. The DOC and ADOC were interviewed and they confirmed the home kept an eight month supply of government stock medications for resident use. The home kept more than a three-month supply of drugs in the home. [s. 124.]

Issued on this 15th day of February, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NATASHA JONES (591), DARIA TRZOS (561), HEATHER PRESTON (640), KATHLEEN MILLAR (527), MICHELLE WARRENER (107)
Inspection No. / No de l'inspection :	2016_467591_0010
Log No. / Registre no:	026434-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 22, 2016; Jan 3, 2017
Licensee / Titulaire de permis :	TYNDALL NURSING HOME LIMITED 1060 EGLINTON AVENUE EAST, MISSISSAUGA, ON, L4W-1K3
LTC Home / Foyer de SLD :	TYNDALL NURSING HOME 1060 EGLINTON AVENUE EAST, MISSISSAUGA, ON, L4W-1K3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Patricia Bedford

To TYNDALL NURSING HOME LIMITED, 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)

Linked to Existing Order / Lien vers ordre existant: 2015_338147_0009, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

Judgement matrix:
Severity of Harm – Minimal harm/Potential for actual harm
Scope – Pattern
Compliance History – Ongoing Non-Compliance with an Order

The licensee shall complete the following:

i) Ensure the care set out in the plan of care is provided to residents as specified in the plan related to diet order and preferences at snack service.

ii) Ensure clear direction is provided in relation to the snack items that are appropriate for each diet type and texture (e.g. therapeutic extension menus) and available for staff providing snacks.

iii) Educate all staff that are involved in the provision of snack delivery on the home's policy related to snack service, and the correct delivery of diet texture and fluid consistency.

iv) Develop and implement Quality initiatives for auditing and improving the snack delivery process to ensure resident safety and satisfaction.

Grounds / Motifs :

1. The licensee failed to ensure that the care set out in the plan of care for residents was provided as specified in the plan at the observed afternoon snack services on September 7, and 14, 2016.

Previously issued March 31, 2016 as a Voluntary Plan of Correction (VPC), May 20, 2015, as Compliance Order (CO), April 8, 2014, as CO, August 21, 2013 as CO, June 20, 2013, as CO.

Observations on September 7, 2016, revealed not all residents received the care set out in their written plans of care at snack pass:

i) Resident #134 had a written plan of care that directed staff to provide a pureed texture menu. The resident was provided two regular textured cookies. Pureed cookies were available on the snack cart; however, the resident was offered and accepted regular cookies. Personal Support Worker (PSW) staff had not referenced the diet list available on the snack cart.

ii) Resident #058 had a written plan of care that directed staff to provide honey consistency thickened fluids. The resident was given thin fluids.

iii) Residents #123 and #133 had written plans of care that directed staff to provide a diabetic diet. Both regular and diabetic drink crystals were available on the snack cart. The residents did not ask for regular crystals; however, were provided regular drink crystals. During an interview, the Registered Dietitian (RD) stated residents on diabetic diets were to receive diet drink crystals unless the resident asked for regular or it was identified in their written plan of care they were to have regular drink crystals.

iv) Residents #100, #054, and #079 had written plans of care that directed staff to provide a regular diet. It was observed that the residents had not asked for; however, were provided diet drink crystals.

v) Resident #086 had a written plan of care that directed staff to provide a pureed texture and nectar consistency thickened fluids. It was observed the resident was offered a pureed snack; however, was not offered a beverage at the snack pass. (107)

Observations on September 14, 2016, revealed not all residents received the care set out in their written plans of care at snack pass.

i) Resident #096 had a written plan of care that directed staff to provide nectar consistency thickened fluids. The resident had not asked for; however, was

provided thin drink crystals. The staff providing the beverage was not aware of the resident's diet until clarified by a Long Term Care Home (LTCH) Inspector. The thin beverage was then removed and thickener was added. PSW #296 confirmed the resident required nectar consistency thickened fluids.

ii) Residents #090, #095, and #089 had written plans of care that directed staff to provide a diabetic diet. Both regular and diabetic drink crystals were available on the snack cart. The residents did not ask for regular crystals; however, were provided regular drink crystals. During an interview, the Registered Dietitian (RD) stated that residents on diabetic diets were to receive diet drink crystals unless the resident asked for regular or it was identified in their written plan of care that they were to have regular drink crystals.

iii) Residents #063 and #074 had written plans of care that directed staff to provide a diabetic diet. The residents had not asked for; however, were provided a coffee or tea with sugar added. Resident #074 had two sugars added to their tea. The RD confirmed that residents requiring diabetic menus were to be offered sweetener unless they specifically requested sugar or it was otherwise identified in their written plan of care.
Resident #074 also required Lactaid milk; however, regular milk was provided in their tea. Lactose reduced milk was available on the snack cart.

Staff delivering snacks provided the name of each resident and confirmed to the LTCH Inspector what was given to each resident during the observed snack pass.

Compliance Order #001, issued in May 2015, required the home to provide training related to the procedures for snack provision and the home's, "Nourishment Cart" policy. Not all staff received the required training. 39 out of 80 (47.6 per cent) of staff attended the required training as confirmed by the Administrator.

(107)

2. Resident #123 had responsive behaviours, which involved resident #154 on two occasions in 2015 and 2016, and another resident in a specified month in 2016. The resident's clinical health record was reviewed and identified on the "Behavioural SBAR - Huddle Communication Tool", and on the written plans of care revised in specified months in 2015 and 2016, that one of the responsive

behaviour mitigation strategies was that staff ensure resident #123 was not seated next to specified residents at any time.
During this inspection on September 2, 3, and 17, 2016, resident #123 was observed seated between two specified residents in the lounge. When registered staff #276, #283 and PSW #287 were interviewed, they confirmed the resident was not to be seated next to the specified residents related to their responsive behaviours. The DOC and ADOC were interviewed and also confirmed the resident was not to be seated next to the specified residents to mitigate responsive behaviours. The home did not ensure the care set out in the plan of care was provided to resident #123 as specified in their written plan of care.
(527)

3. Observations by a Long Term Care Home (LTCH) Inspector of resident #093 on September 13, 14, and 15, 2016, between specified hours revealed staff did not assist them to stand every two hours while up in their wheelchair.
A review of the resident's written plan of care, revised in a specified month in 2016, directed staff to remove the safety device and stand the resident up every two hours when they were in their chair.
In interviews on September 13 and 14, 2016, Person Support Workers (PSWs) #282 and #288 confirmed staff did not stand the resident up every two hours when they were in their chair. In an interview on September 14, 2016, the physiotherapy assistant (PTA) confirmed the expectation of staff to stand the resident up. In an interview on September 14, 2016, the Director of Care (DOC) and the Assistant Director of Care (ADOC) confirmed staff did not provide care as specified in the written plan of care for resident #093.
(591)

4. Observations of resident #088 throughout the course of the inspection revealed a safety device was attached from the resident's wheelchair to their clothing while they were in the chair. On September 7, 2016, a Long Term Care Home (LTCH) Inspector observed the resident get up from their wheelchair; however, the safety device was not attached to their clothing or the chair. Personal Support Worker (PSW) #266 assisted the resident back to the chair, retrieved the safety device from the resident's room, and attached it to the chair and resident.
A review of resident #088's clinical health record revealed they had a fall in July 2016, which resulted in an injury. A review of the resident's written plan of care, last revised July, 2016, indicated staff were to ensure the safety device was in

place and were to respond promptly as indicated, and identified the resident as being a high risk for falls. In interviews on September 7 and 14, 2016, registered staff #259, and PSW #266 confirmed the safety device was not attached to resident #088, but should have been, as per their written plan of care.
(591)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2017

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_189120_0002, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Order / Ordre :

Judgement matrix:
Severity of Harm – Minimal harm/Potential for actual harm
Scope – Pattern
Compliance History – Ongoing Non-Compliance with an Order

The licensee shall complete the following:

i) Ensure a translator is available to assist resident's with language barriers, to facilitate their input into the development of interventions and strategies related to their plan of care.

ii) Re-assess interventions or strategies that were implemented for residents who cannot communicate in the language or languages used in the home to ensure that the strategies or interventions met the needs of residents,

iii) Ensure the written plans of care are updated with the strategies or interventions in place to reflect the current needs of residents with communication barriers,

iv) Provide education to all direct care providers in the home on the "Communication: Barriers to Language, Cognition and Medical" policy which related to the use of available communication tools, strategies and interventions to meet the needs of residents with communication barriers.

Grounds / Motifs :

1. The licensee failed to ensure strategies were developed and implemented to meet the needs of residents who could not communicate in the language or languages used in the home.

A) An order was issued for this non-compliance on May 2015, with a compliance date of July 2015. A Follow Up inspection was conducted in January 2016, and the report was issued in February 2016. The order was re-issued with the compliance date of March 2016.

B) The order re-issued in February 2016, ordered the home to provide training to staff on the use of available communication tools, strategies and interventions to meet the needs of residents who did not communicate in the language or languages used in the home. The home's training records were reviewed during this inspection and indicated the home had trained 73 per cent (%) of all staff in 2015, in a session titled "Communication: Barriers to Language, Cognition and Medical" which included strategies to communicate with residents, and an evaluation of the effectiveness of the communication strategies and use of picture boards. The training records also indicated the due date for this education was September 2016.
In interviews in September 2016, PSW #273 and registered staff #250 confirmed they had not attended the above mentioned communication training. The DOC in an interview also in September 2016, confirmed the home had not trained all staff in the home in 2015, and were still at 73% trained as of September 2016.

C) Residents #061 and #091 were interviewed during this inspection. Through interviews with the residents, staff, and review of their clinical health record, it was identified that the home continued to be in non-compliance with section 43 of the Long Term Care Homes
Act (LTCHA).

i) During previous inspections, in April 2015, and January 2016, it was identified resident #061 was not able to understand the staff when gestures, words or facial expressions were employed as instructed by their written plan of care. During the previous inspection in January 2016, it was identified that the home had incorporated a specified strategy to help with communication; however, they were proven to be ineffective.
During this inspection, resident #061 was interviewed. The resident confirmed

they could not communicate with staff in the home and there were no tools implemented in the home to assist them with communication. The resident identified a medical condition that interfered with their ability to use the pictures/communication cards. Resident #061 verbalized feelings of loneliness, as they were unable to fully communicate their needs to staff in the home.
A review of a progress note in a specified month in 2016, indicated the home had reassessed the use of the picture board, had identified that this strategy was ineffective and the resident was able to understand staff. The most recent written plan of care was not updated to reflect the re-assessment.
PSW #273 and registered staff #250 that provided direct care to the resident were interviewed and stated they used gestures to communicate with resident #061 and the resident was able to understand.
The DOC confirmed the written plan of care should have been updated. There was no evidence that any other interventions or strategies were tried or implemented. The DOC stated the home had discussed purchasing an electronic device but that had not yet been implemented. The home could not provide documentation to confirm the discussion.

ii) During this inspection, resident #091 was interviewed. The resident confirmed they could not communicate with staff in the home. The resident was observed to have picture/communication cards; however, the resident stated they could no longer read as a result of a medical condition. The resident was unable to interpret the message behind the pictures, and confirmed the picture cards were not used by the staff. Furthermore, the resident verbalized there were no staff working in the home who they could communicate with. The resident verbalized feelings of loneliness and inability to fully enjoy and interact with other residents and staff during activities.
In an interview, PSW #273 that provided direct care to the resident confirmed the picture/communication board was not being used for the resident. The resident's clinical health records were reviewed and the most recent written plan of care provided several specified directions related to communication.
In an interview on September 9, 2016, the NM confirmed the home had completed evaluations of the use of picture/communication boards for residents with language barriers. The "Communication Evaluation" sheet indicated the use of picture/communication boards were effective for resident #091. The evaluation was not dated and the NM could not recall when it was completed.
In an interview on September 9, 2016, the DOC confirmed they did not know when the evaluation was completed and further they were not aware resident #091's medical condition affected their ability to use the picture/communication

board, nor were they aware the picture/communication board was not being used by staff or the resident. The DOC confirmed the strategies and interventions that had been implemented to facilitate communication with the resident should have been re-evaluated when they were no longer effective.

After the inspection was completed, another copy of the evaluation was sent from the home to a LTCH Inspector via email with a written date on the evaluation which was March 2016.
(561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2017

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,

(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and

(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

Judgement matrix:
Severity of Harm – Minimal harm/Potential for Actual Harm
Scope – Pattern
Compliance History – Previous on-going Non-Compliance

The licensee shall complete the following:

i) Provide all maintenance staff with access to a copy of the most recent written maintenance policies and procedures and ensure that all maintenance staff have reviewed the policies and procedures.

ii) Provide all staff in the home who are not maintenance personnel and who are required to report maintenance deficiencies with a written copy of their roles and responsibilities in reporting deficiencies/safety issues within and around the home and the process they must follow.

iii) Re-audit or re-assess any resident rooms, ensuite washrooms, common washrooms, common spaces (including corridors), dining rooms and tub/shower rooms to determine whether all maintenance related deficiencies have been identified and documented. The audits shall be completed by December 15, 2016, and the documentation or results of those audits retained at the home for future review.

iv) Establish a schedule (time frames) and the person responsible to address the maintenance issues identified during the audit process along with the issues identified in the grounds below. The schedule shall be established by December 31, 2016, and submitted to LTCH Inspector, Natasha.G.Jones@ontario.ca by January 7, 2017.

v) An ongoing remedial maintenance program shall be in place in the home throughout the year to address identified maintenance deficiencies/safety issues in a timely and effective manner.

Grounds / Motifs :

1. As part of the organized program of maintenance services under clause 15(1) (c) of the Act, the licensee failed to ensure procedures and schedules were in place for routine and remedial maintenance.

The home's maintenance policies were revised in May 2016; however, the

policies had not been implemented within the home and staff had not been trained on the new policies as of September 2016. The home's policy, #FSM-C-10, titled "Preventative Maintenance Schedule ", directed the Director of Facility Services to complete a monthly preventative maintenance report and forward to the facility Administrator. Routine preventative maintenance audits were in place and documentation was reviewed confirming that the audits were conducted and scheduled. No schedules were in place for review to determine which tub or shower rooms, resident rooms and bathrooms were to receive the required repairs, particularly for walls, vanities, floors, baseboards and door trims.
The home's policy #FSM-C-122, titled "Maintenance Procedures ", identified that during audits, staff were to check to ensure that there were "no cracks, peeling arborite, stains or other damage on vanities; check for chips, stains, rust on sinks; faucets should be in good repair, open freely, no evidence of rust; floors should be checked for cracks, stains, paying particular attention to evidence of urine soaking under tiles and replace as needed; and tubs and shower stalls were to be checked for any cracks, chips or stains".
The home's policy # FSM-C-120, titled "Painting ", directed staff to paint room(s) or areas per month as per outline for priority areas. Areas were to be inspected for "the need for repairs of any damaged walls prior to painting, and to replace and repair any baseboards following painting".
Routine remedial maintenance was not consistently being completed in the home. The Administrator confirmed that the entire home was painted in June 2015, and additional painting was completed in three specified rooms in July 2016. A schedule was not established to continue routine painting as needed and as identified by the audits completed. Multiple rooms were identified as in need of painting during this inspection.
During the inspection, tours of the home were completed on August 30 and September 9, 2016, and the following areas of disrepair were identified:

i) Baseboards were missing or pulled out from the wall in eight specified rooms. On August 22, 2016, the maintenance request book noted baseboards coming off the walls in six specified rooms; however, a date for rectifying or addressing the issue was not identified.

ii) Washroom vanities had exposed particle board resulting in rough edges that would be difficult to clean and could pose safety concerns in three specified rooms. The vanity in one specified room had not been identified on the "Environmental Tracking Form - Replacement of Bathroom Counters & Sink

updated July 2016" form, and the vanity in one specified room identified a re-check was required but no action was documented.
The second floor shower room had chips in the counter top edges, resulting in areas that were rough and not sealed and the vanity in one specified room was lifting.

iii) Walls/Ceilings/floors. The Administrator confirmed the home had been painted in 2015, and two specified rooms were re-painted in July 2016; however, a schedule for the remedial component of the maintenance program for all rooms was not in place. The maintenance request book included areas that required maintenance/painting on August 22, 2016, for three specified rooms and third floor east hallway; however, the work was not scheduled and had not been completed by the time of this inspection.
During the inspection four specified rooms were identified as requiring repair or painting (the whole home was not inspected). Painting was needed around almost all bathroom doors on the third floor as the paint was chipped and coming off. Paint on the 3rd floor linen room door was also flaking. The third floor shower room had some cracked or chipped wall tiles in corner by the wall heater, one specified room had a large divot in the new floor tile in the room entrance, and another specified room had two missing ceramic floor tiles at the entrance to the bathroom. In the fourth floor shower room the baseboard heater was rusty and the tiles in the shower area were cracked. In the third floor shower room the baseboard heater was severely dented. In the second floor shower room the floor had a split in it just before the transition into the shower area. In the second floor tub room, the flooring in the shower enclosure had splits in the flooring material (previously identified during inspections in April 2015, and January 2016), the cover had fallen off the baseboard heater, there was wall and tile damage just above the baseboards by tub and toilet areas, and apparent water damage on the ceiling (paint bubbled on ceiling above).

iv) Rust was noted around the sink drains in two specified rooms. A leaky faucet was noted in one specified room which wasn't identified in the maintenance book until September 8, 2016, when the LTCH Inspector inquired about it. The resident stated that it had been leaking for quite some time prior to that. The faucet was still leaking as of September 14, 2016.

v) Urine odours were noted in the washroom of one specified room creating an ongoing urine odour in the washroom that was present throughout the course of the inspection. It was suspected that urine may have seeped into a location

within the bathroom that could not be cleaned.

vi) Handrails on both the second and third floor were in poor condition with rough areas and chipped sections and in some cases, covered with duct tape. The Administrator reported that plans were proposed to remove and replace the handrails but no specific dates could be provided.
(107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2017

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

Judgement matrix:
Severity of Harm – Minimal harm/Potential for Actual Harm
Scope – Isolated
Compliance History – Previous unrelated Non-Compliance

The licensee shall complete the following:

i) Ensure that with respect to the restraining of a resident by a physical device under section 31 or section 36 of the act, staff apply the physical device in accordance with any manufacturer's instructions, and

ii) Ensure that manufacturer's instructions for all physical devices used to restrain residents under section 31 or section 36 of the Act are readily available for all staff who apply the physical devices.

Grounds / Motifs :

1. The licensee failed to ensure the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: staff applied the physical device in accordance with any manufacturer's instructions.

Observations of resident #093 by a LTCH Inspector on September 13, and 14, 2016, at specified times, revealed the resident was secured with a safety device while sitting in their wheelchair. The LTCH Inspector was able to test the device and confirm that it was not being used appropriately.
In interviews on September 13, 2016, with PSW #282, and September 14, 2016, with PSW #288, and registered staff #250 confirmed the resident was sometimes able to release the safety device independently; however, most of the time they could not. In interviews, PSW's #282, #288, and registered staff #250 did not know how to use the safety device appropriately to ensure the resident was safe, and further confirmed resident #093 was at risk.
A review of a document titled "Future - Orion III –Owner's Manual" provided direction for the user on how to use the safety device appropriately. A review of policy #CPME-10, titled "Restraints - Overview", indicated the safety device must be applied in strict accordance with manufacturer's specifications. A review of the home's 2015 and 2016 restraint training materials did not include safety related to the safety device use.
The safety device used for resident #093 was not applied in accordance with the manufacturer's instructions.
(591)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2017

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

Judgement matrix:
Severity of Harm – Minimal harm/Potential for Actual Harm
Scope – Pattern
Compliance History – Previous related Non-Compliance

The licensee shall complete the following:

i) Ensure that all staff who provide direct care to residents receive training related to continence care and bowel management on an annual basis, or based on the staff's assessed training needs,

ii) Ensure that continence care and bowel management training materials include, but are not limited to, training on the home's continence program, policies and procedures,

iii) Ensure that all staff who apply physical devices or who monitor residents restrained by physical devices, receive training in the application, use and potential dangers of these physical devices on an annual basis, or based on the staff's assessed training needs,

iv) Ensure that Personal Assistance Services Device (PASD) training materials include, but are not limited to, all of the legislated requirements related to PASD use and,

v) Ensure that the home develops and implements a written policy to minimize restraining of residents to ensure any necessary restraining of residents is done in accordance with the legislation.

Grounds / Motifs :

1. The licensee failed to ensure training related to continence care and bowel management was provided to all staff that provided direct care to residents either annually or based on the staff's assessed training needs.

In an interview, the DOC confirmed not all direct care staff received the required training in 2015 or to date in 2016. An education session for direct care staff was held October 2015; however, only 44 out of 70 (62.8%) attended the education session. The education was focused on incontinence products and did not include education related to the home's continence program, policies and procedures, and assessments. (107)

2. The licensee failed to ensure training was provided to all staff who applied physical devices or who monitored residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.

In interviews on September 7, and 14, 2016, registered staff #259 and #263 confirmed they had not received restraint training in 2015 or 2016. In interviews on September 7, and 14, 2016, PSW's #266, #287, and #288 confirmed they had not received restraint training in 2015 or 2016. In an interview on September 15, 2016, the DOC confirmed 32 out of 95 (34%) of direct care staff completed the training session, titled "Falls Prevention
Program and Least Restraint", offered April 2015. They further confirmed restraint training for 2016 had not yet been completed by all staff.
The licensee did not ensure all staff that provided direct care to residents received restraint training in 2015.
(591)

3. The licensee failed to ensure for staff who applied PASD's or monitored residents with PASD's, training in the application, use and potential dangers of the PASD's.

A review of the 2015 and 2016 training materials did not include all of the legislated requirements related to PASD use. The DOC presented a draft of a policy titled "Personal Assistive Services Device – PASD's", and confirmed the draft had not yet been approved or presented to the staff.
In interviews on September 7 and 14, 2016:
- registered staff #259 confirmed tilt wheelchairs were used for comfort and positioning of residents, and also had restraining features,
- registered staff #250 was unsure whether a tilt wheelchair was a PASD or a restraint, and
- registered staff #263 stated they had been instructed not to recline residents in tilt wheelchairs as restraining of residents in the home was not permitted.
All of the above mentioned staff, including PSW's #266, #287, and #288, confirmed in interviews on September 7 and 14, 2016, they had not received PASD training in 2015, or 2016.
In an interview on September 15, 2016, the DOC confirmed 32 out of 95 (34%) of direct care staff completed the training session, titled "Falls Prevention Program and Least Restraint", offered April 2015.
The licensee did not ensure all staff that provided direct care received PASD

training in 2015.
(591)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2017

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Order / Ordre :

Judgement matrix:
Severity of Harm – Minimal harm/Potential for Actual Harm
Scope – Isolated
Compliance History – Previous unrelated Non-Compliance

The licensee shall complete the following:

i) Ensure that where a resident is being restrained by a physical device under section 31 of the Act, staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class, and

ii) Ensure documentation of the above mentioned order is included in resident #148 and all other applicable residents' clinical health records.

Grounds / Motifs :

1. The licensee failed to ensure the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act: that staff only apply the physical device that had been ordered or approved by a physician or registered nurse in the extended class.

Observations on September 14 and 15, 2016, revealed resident #148 was in a wheelchair which was reclined. Observations by a LTCH Inspector on September 14, 2016, revealed PSW #287 had tilted the resident back to a lying position in their wheelchair. The PSW in an interview at the time of the observation stated the wheelchair was used as a personal assistance services device (PASD) for the resident for comfort and repositioning, and further confirmed resident #148 could not get out of the tilt wheelchair independently if the chair was reclined. This was also confirmed by registered staff #263.
A review of the resident's clinical health record revealed an order for restraint was not obtained, and an assessment for the use of the wheelchair could not be located. This was confirmed by registered staff #263. A review of the resident's most recent written plan of care did not identify the use of the wheelchair as either a PASD or a restraint.
In an interview on September 15, 2016, the DOC and ADOC confirmed an order for the use of a restraint for resident #148 should have been obtained prior to use.
(591)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 22nd day of December, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Natasha Jones

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