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 prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l’inspection	Log #/ Registre no	Type of Inspection / Genre d’inspection
Aug 26, 2016;	2016_205129_0005 (A1)	008334-16	Resident Quality Inspection

Licensee/Titulaire de permis

955464 ONTARIO LIMITED
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

VALLEY PARK LODGE
6400 VALLEY WAY NIAGARA FALLS ON L2E 7E3

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

PHYLLIS HILTZ-BONTJE (129) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance dates changed for Order #001, #002, #003, #004, #005, #006, #007 and #008.
Changes made to Order #002, specifically dates added to #1 and #3 of this order.

Issued on this 26 day of August 2016 (A1)

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

Original report signed by the inspector.

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PHYLLIS HILTZ-BONTJE (129) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): March 29, 30, 31, April 1, 5, 6, 7, 8, 12, 13, 14, 15, 18, 19, 20, 21, 22 and 25, 2016

The following inspections were completed concurrently with this Resident Quality Inspection: Complaint Inspection #020583-15 related to continence care, assessment of pain and nutritional issues and management of complaints, Critical Incident System (CIS) Inspection # 016507-15 related to management of complaints, CIS Inspection #013379-15 related to falls, CIS Inspection #00651-15 related to non-consensual touching, CIS Inspection # 025842-15 related to injury during transfer, CIS Inspection #004632-14 related to inappropriate touching, CIS Inspection # 001584-15 related to inappropriate behaviour and Complaint Inspection #009330-15 related to staffing.

During the course of the inspection, the inspector(s) spoke with residents, resident's family members, personal support workers (PSW), registered practical nurses (RPN), registered nurses (RN), Director of Therapeutic Recreation Services, recreation aides, Food Service and Nutrition Manager (FSNM), dietary aide, Director of Care (DOC), Assistant Administrator, Environmental Supervisor, Environmental Services Supervisor, Registered Dietitian, Resident Assessment Instrument (RAI) Coordinator (RAI) Physiotherapist, President of the Residents' Council and President of the Family Council.

During the course of this inspection inspectors observed residents and care provided to residents, reviewed clinical record documents, incident notes made by the home, staffing schedules, policies, procedures and protocols as well as training records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

- **20 WN(s)**
- **10 VPC(s)**
- **8 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff.

a) A review of the Critical Incident report submitted by the home, indicated that on an identified date, staff #076 witnessed resident #302 inappropriately touch resident #303.

Resident #303 was competent; however, experienced communication difficulties due to health conditions. Staff #076 separated the two residents and asked resident #303 if they felt uncomfortable with resident #302's actions and resident #303 indicated they did.

It was confirmed through documentation and during an interview with the DOC on April 22, 2016, that resident #303 was not protected from abuse by anyone.

b) Resident #300 had a diagnosis of dementia and a history of recurring infections. The resident had appointed two family members as Substitute Decision Makers (SDM) for health care decisions.

A review of the resident’s clinical record indicated that staff had observed and documented that on an identified date, the resident was lethargic, confused and did not “seem them self”.

Twenty five days later, the resident complained of pain all over and had requested to go to bed after supper due to not feeling well.

Thirteen days following the above noted incident, family were in to visit resident #300 and had identified that the resident was very confused and reported to staff that the resident could not feed them self and required family assistance for eating, which was not typical for the resident. During this visit the family requested a laboratory specimen be obtained as they suspected the resident had an infection.

Ten days after the SDM had requested a laboratory specimen be obtained and while attending a care conference for resident #300, the SDM again requested that a specimen be obtained as the SDM was still concerned with the resident’s decline in their cognitive status and the home had still not obtained the specimen. The SDM also indicated at this meeting that in the past, the resident would exhibit the symptom of cognitive decline when the resident had an infection and would improve when treated with antibiotics.

Four days after the SDM made the second request to have a specimen obtained, the resident complained of back pain and requested to go to bed after breakfast.

The following day, staff had identified that the resident was weak and could not feed them self. Two days after staff made the above noted observations of the resident, it was identified that the resident was unusually sluggish, slow when responding to questions and not answering questions appropriately.

Two days later, it was again identified by staff that the resident was lethargic and had difficulty swallowing food. Further review of the clinical record indicated that the resident continued to have a decline in their health condition and 18 days later, the resident became anxious and was breathing rapidly. When staff asked the resident why they were breathing that way, the resident responded “if I stop I will die”.

Five days later staff noted that the resident’s condition remained unchanged and staff obtained the specimen that had been requested for the second time by the SDM’s 33 days earlier. Staff did not follow the home's medical directives related to a specific infection and specifically the method of obtaining specimens related to this infection. Staff contaminated the specimen when they did not follow the home's medical directives for obtaining this specimen; however, the specimen confirmed that the resident had an infection and five days later, the Physician ordered an antibiotic to be taken for five days.

After the completion of the antibiotics, the resident continued to exhibit symptoms of confusion, lethargy, decreased appetite and behavioural changes. The clinical record indicated that staff documented two days after the start of the treatment for this infection, 12 days after the start of the treatment and 14 days after the start of the treatment, resident #300 had repeated bouts of emesis and family requested that the home send the resident to hospital due to their condition.

The resident was transferred to hospital and was hospitalized for five days due to this infection, dehydration and other complications.

It was confirmed by the Director of Care (DOC) during an interview on April 7, 2016, that resident was neglected by staff when the home failed to provide the resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction that jeopardized the health, safety or well-being.

PLEASE NOTE: This area of non-compliance was identified during a complaint inspection, log #020583-15, conducted concurrently during this RQI. (508)

c) A review of the Critical Incident report submitted by the home on March 2, 2015, indicated that on an identified date, resident #304 was witnessed by staff to inappropriately touch resident #305.

The staff member intervened, separated the residents and removed resident #305 from the area. A review of resident #305’s clinical record indicated that resident #305 had severe cognitive impairment and was not capable of consenting to any inappropriate touching.

It was confirmed through documentation and during an interview with the DOC on April 22, 2016, that resident #305 was not protected from abuse by resident #304.

PLEASE NOTE: This area of non-compliance was identified during a Critical Incident inspection, log #003651-15, conducted concurrently during this RQI. [s. 19. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure where bed rails were used, the resident was assessed, his or her bed system was evaluated and steps were taken to prevent resident entrapment, in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. [15(1) (a) (b)]

Prevailing practices are identified in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), the decision to use, continue to use, or to discontinue the use of a bed rail should be made within the context of an individual resident assessment using an interdisciplinary team with input from the resident or the residents substitute decision maker. The guideline emphasizes the need to document clearly whether interventions were used and if they were appropriate or effective. Other questions to be considered would be the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors, the status of the resident's bed (whether passed or failed zones 1-4). Consideration of these factors could more accurately guide the assessor in making a decision, with either the resident or by the resident's Substitute Decision Maker (SDM) about the necessity and safety of a bed rail. The final conclusion would then be documented on a form (electronically or on paper) as to why one or more bed rails were required, the type of rail, when the rails were to be applied, how many, on what sides of the bed and whether any accessory or

amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

a) The licensed failed to assess residents in accordance with prevailing practices when the use of bed rails was included in the resident's plan of care.

1. During the initial course of this inspection, Inspector # 214 observed that resident #007 had two quarter bed rails in the “up” position on their bed. A review of the resident's plan of care indicated that two quarter bed rails were used as personal assistive services devises (PASD) and that the resident would use the bed rails to assist in positioning while in bed. At the time of this inspection registered staff #029 confirmed that they were unable to provide any documentation to confirm that resident #107 had been assessed prior to the bed rails being added to the resident's plan of care.

2. Observations made on April 19, 2016 of resident #201's bed system confirmed the mattress was not held within the mattress keepers, slid easily from side to side on the bed deck and a three quarter length bed rail was noted in the “up” position on the left side of the bed. Resident #201's plan of care indicated under both a safety and mobility care focuses that the resident used one three quarter bed rail for positioning. The Resident Assessment Instrument (RAI) Coordinator confirmed that the assessment tool staff used when an assessment for the use of bed rails was required was titled “Safety Assessment – falls, restraints and bed rails” and that this tool was also used when a reassessment of the resident's need for the use of bed rails was completed. The above noted “tool” completed for resident # 201 on February 11, 2016 confirmed that registered staff selected data points that indicated the bed rail was at the request of the resident/family, a “Living at Risk” form had been signed and the bed rail was used for personal care, but did not identify how or why this resident used the bed rail during personal care. Registered staff #029 and the clinical record confirmed that there was no documentation on the assessment form, in progress notes or in any other part of the clinical record that assessed the resident's need/ability to use the three quarter bed rail on the left side of the bed for personal care or what alternatives to the use of one bed rail were considered at the time of the assessment.
A reassessment of the use of one three quarter bed rail on the left side of the bed for resident #201 was completed using the above mentioned assessment tool on April 26, 2016. The registered staff completing this assessment selected the same data points as were selected on the February 11, 2016 assessment. A review of the clinical record confirmed that there was no documentation on the assessment

tool, in progress notes or in any other part of the clinical record that demonstrated the resident was observed for the use of the bed rail, that there was an ongoing need for the use of the bed rail or if alternatives to the use of the bed rails were considered at the time of the reassessment.

3. Observations made on April 21, 2016 of resident #202's bed system confirmed that the mattress was not held within the mattress keepers, the mattress slid easily from side to side on the bed deck and one three quarter bed rail was noted in the "up position on the left side of the bed. Resident #202's plan of care indicated under both a safety and mobility care focuses that the resident used one three quarter bed rail to assist with bed mobility. The resident's initial "Safety Assessment- falls, restraints and bed rail" tool completed on May 13, 2015 indicated that the resident had requested the bed rail, the resident had signed a "Living with Risk" form, bed rails were not needed during personal care and the resident had a three quarter bed rail at night to help with repositioning. Data collected and documented in the clinical record indicated resident #202's physical functioning, specifically related to bed mobility deteriorated from requiring supervision with one person physical assist on June 8, 2015, to requiring extensive assistance with one person physical assist on August 7, 2015 and then to requiring extensive assistance with two (plus) person physical assist on November 7, 2015. Documentation indicated that the resident continued to require extensive assistance with two (plus) person physical assist from January 30, 2016 up to and including the time of this inspection. Bed rail reassessments completed for resident #202 on August 15, 2015 and February 18, 2016 were not based on an individual resident assessment when there was no indication of the impact of the resident's deteriorating condition related to bed mobility and this factor was not considered in determining the ongoing need for the use of bed rails for this resident.

b) The licensee failed to assess resident's bed systems in accordance with prevailing practices when the uses of bed rails were included in the resident's plan of care.

During the initial phase of this inspection it was observed by both Inspector # 514 and Inspector # 129 that several resident bed systems were observed to not have the mattresses contained within the mattress keepers and those mattresses slid from side to side easily on the bed deck.
The Environmental Supervisor (ES) confirmed that they had completed a bed entrapment audit on March 10, 2016, that they were trained to complete this audit by an identified bed/mattress manufacturer and that the home had and used the

appropriate equipment while completing this audit. The record of this audit indicated that all bed systems in the home passed entrapment zones except one and there was no indication on this record that there was an issue with the mattresses not being contained within the mattress keepers or that mattresses were noted to slide easily from side to side on the bed decks. A review of resident’s bed systems was completed with the ES on April 21, 2016. The ES confirmed following this review that of the 32 occupied beds reviewed, 23 of those beds failed to meet bed system safety requirements and these bed systems failed because the mattresses were not contained within the mattress keepers and all of these identified mattresses were noted to slide easily from side to side on the bed decks. It was also noted during this review that all 23 bed that failed were noted to have one or more bed rails in the “up” position. During the course of the review of bed systems PSW staff #033 and #062 entered one of the rooms while this Inspector and the ES were reviewing the bed systems and indicated that the fitted sheets being used in the home were so tight that they pulled the mattresses up out of the mattress keepers and at the time of this review the ES considered this situation as a possible cause of the mattresses not resting in the mattress keepers and creating potential entrapment risks.

c. The licensee failed to ensure that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [15(1)(b)]

While reviewing the “Bed/Entrapment Audit Report” completed by the ES on March 10, 2016, it was confirmed that one bed system had failed to prevent possible resident entrapment. The ES confirmed that this bed system had failed because the mattress was an air surface. Observations of this bed system made with the ES and the Maintenance Lead confirmed that there was an air mattress on the bed and one three quarter bed rail was noted in the “up” position on right side of the bed. The ES indicated the resident had signed a “Living at Risk” form and that no action had been taken to mitigate the risk of potential entrapment for this resident. [s. 15. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

s. 6. (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).

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident. [6(1) (a)]

A review of a Critical Incident System (CIS) report that was completed by the home indicated that on an identified date, while staff were assisting resident #404 to transfer from their bed to their chair was using a mechanical lift, they became weak, resulting in a fall onto the floor. The resident sustained two injuries as a result.

A review of the resident's written plan of care in place for 60 days prior to the incident, indicated that there was no plan or interventions in place regarding the residents needs and preference for how the resident was to be transferred; any transferring and positioning devices or techniques to be used and how many staff were required during transfer of the resident.

An interview with the DOC and the RAI Coordinator confirmed that there was no plan in place regarding the resident's needs for transferring and lifting at the time of this incident when the resident sustained a fractured hip as a result of a fall from

their transferring device.

PLEASE NOTE: The above noted non-compliance was identified while conducting a Critical Incident System (CIS) Inspection #025842-15, concurrently with this RQI. (Inspector #214) [s. 6. (1) (a)]

2. The licensee failed to ensure that there was a written plan of care for each resident set out clear directions to staff and others who provided direct care to the resident. [6(1) (c)]

a) Resident #109's written plan of care did not provide clear in relation to a care focus to address an identified visual impairment. The resident was identified as having a visual impairment with decreased visual acuity related to aging for which they no longer used corrective lenses. The DOC, PSW staff #047, PSW staff #049 and the written plan of care confirmed that care interventions did not provide clear directions to staff who provided care when the plan directed staff to "adapt the environment to the resident's individual needs to ensure they are able to recognize their own environment". The above noted staff confirmed that the written plan of care did not provide specific information related to the needs of the resident or how the environment was to be adapted. (Inspector #129)

b) The written plan of care for resident #109 did not provide clear direction for staff, in relation to the application of a restraining device. The resident's written plan of care directed staff "to ensure the restraining device was securely snug to fit the resident". PSW staff # 070 confirmed that the vendor who affixed the restraining device indicated that staff were to apply the device in a very specific way to ensure it was correctly applied for this resident. This direction for the application of the restraining device was confirmed by a diagram included in the home's restraint policy. The resident's plan of care did not provide this specific direction to staff providing care and on March 31, 2016 it was observed and confirmed by registered staff # 011 and PSW staff #070 that the restraining device had not been applied according to the specific directions and had been applied in an unsafe manner with a 14 inch gap between the resident's body and the restraining device. (Inspector # 129)

c. A review of resident #100's written plan of care dated October 21, 2015, indicated under oral care that staff was to provide supplies for oral hygiene and staff were to remind and set up the resident to ensure care was completed. The same written plan also indicated that staff was to provide assistance of one staff to

set the resident close to the sink and provide their oral care.

An interview with the DOC and the RAI Coordinator confirmed that the resident's written plan of care in relation to their oral care needs had not set out clear directions to staff and others who provided direct care. (Inspector #214) [s. 6. (1) (c)]

3. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident. [6(2)]

a) A bladder and bowel assessment had been completed for resident #108 in January and in March, 2016. A review of these assessments indicated that the resident was frequently incontinent of urine and occasionally incontinent of bowel.

The resident's plan of care for this time period identified that the resident was frequently incontinent of urine. The plan also identified that the resident was on a toileting program to assist the resident in managing their urinary incontinence.
The plan of care did not contain any of the information related to the resident's level of bowel continence as identified in the bowel and bladder assessments.
It was confirmed by the RAI Coordinator during an interview on April 18, 2016, that the care set out in the resident's plan of care was not based on an assessment of the needs and preferences of that resident. (Inspector # 508)

b) The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A review of resident #100's Oral Health Assessment dated October 11, 2015, indicated that barriers to oral care or dental treatment for the resident were that the resident refused oral hygiene and would not open their mouth. The assessment indicated that the resident used a sponge swab and oral rinse for their oral care need supplies. The assessment indicated under details and interventions for oral health and hygiene that one staff was to set up the resident at the sink with a glass and oral rinse and that staff were to observe and cue the resident while they rinse their mouth with mouth wash. Staff was to also use a sponge swab to clean the resident's mouth as they will turn away when a toothbrush is used.

A review of the resident's written plan of care for oral care dated October 21, 2015, indicated that one staff was to set up the resident at the sink and cue the resident

to rinse their mouth in the morning and at bedtime; however, the plan had not indicated that the resident may refuse oral hygiene or may not open their mouth and also had not indicated that staff were to use a sponge swab to clean the resident's mouth as they may turn away when a toothbrush is used.

An interview with the DOC and the RAI Coordinator confirmed that the care set out in the plan of care was not based on the assessed needs and preferences of the resident. (Inspector #214)

c) A review of resident #102's quarterly minimum data set (MDS) coding dated December 12, 2015, indicated under section H. - Continence in the last 14 days that the resident was coded as being frequently incontinent of their bladder and that their urinary continence had not changed as compared to their status 90 days ago. A review of the corresponding narrative Urinary Continence Resident Assessment Protocol (RAP) also indicated that the resident was frequently incontinent of their bladder.
A review of the resident's written plan of care dated December 17, 2015, indicated under the focus for toileting and urinary incontinence, that the resident was occasionally incontinent of their bladder.
An interview with the RAI Coordinator on April 14, 2016, confirmed that the care set out in the plan of care had not been based on an assessment of the resident and their needs. (Inspector #214)

d) A review of a Critical Incident Submission (CIS) that was completed by the home indicated that on an identified date, while staff were assisting resident #404 to transfer from their bed to their chair using a mechanic lift, they became weak, resulting in a fall onto the floor. The resident sustained two injuries as a result.
A review of the resident's written plan of care for the time period of August 29 – October 8, 2015, indicated under the transfer focus that the resident was to be transferred via total mechanical lift with two persons in attendance. The created date of this intervention was August 30, 2015. According to the resident's clinical records, the resident was not in the home at the time this intervention had bee added to the plan of care.
An interview with the DOC and RAI Coordinator confirmed that the resident was not in the home at the time this intervention was added to the plan of care and that the plan of care had not been based on the assessed needs and preferences of the resident.

PLEASE NOTE: The above noted non-compliance was identified while conducting

a Critical Incident System (CIS) Inspection #025842-15, concurrently with this RQI. (Inspector #214) [s. 6. (2)]

4. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other. [6(4)(a)]

a) Resident #108 was occasionally incontinent for bowel. A review of the resident's clinical record indicated that a quarterly bladder and bowel assessment had been completed on March 18, 2016, which identified that the resident had occasional fecal episodes.

A review of the MDS coding under section-H, continence in the last 14 days, date March 19, 2016, identified that the resident was continent of their bowel.

During an interview with staff #074, it was confirmed that resident #108 did have occasional fecal episodes.

It was confirmed during an interview with the RAI Coordinator on April,18, 2016, that the staff and others involved in the different aspects of care of the resident had not collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.(Inspector # 508)

b) A review of resident #100's quarterly MDS assessment dated September 19, 2015, indicated under the Resident Assessment Protocol (RAP) for Dental Care that the resident required staff to provide total oral care twice daily a majority of the time. A review of an Oral Health Assessment completed for the resident and dated October 11, 2015, indicated that the resident required extensive assistance of one staff for their level of assistance required for oral care.

An interview with the DOC and RAI Coordinator confirmed that the assessments completed above were not integrated, consistent and did not complement each other in regards to the level of assistance that resident #100 required for their oral care needs. (Inspector #214)

c) A review of resident #101's MDS quarterly review coding, dated December 12, 2015, indicated under section P.-Special Treatments and Procedures that the

resident was coded as having a restraining device used daily. A review of the corresponding narrative Physical Restraint RAP indicated no mention of a restraining device.

A review of the Safety Assessment-fall, restraint & bed rail-V4, dated December 19, 2015, indicated that the resident used three different types of restraining devices.

An interview with the DOC confirmed that the resident did use one of the restraining devices noted above, had used this device for approximately two years and that staff involved in the different aspects of care of the resident had not collaborated with each other so that their assessments were integrated, consistent and complemented each other. (Inspector #214)

d) A review of resident #102's clinical record indicated that an Oral Health Assessment was completed on March 24, 2016, and identified that the resident had a limited number of teeth and used a toothbrush and toothpaste for their oral care. A review of the resident's quarterly Minimum Data Set (MDS) coding that was dated March 12, 2016, indicated that the resident was not coded as having some or all natural teeth lost and as a result, the Dental Care narrative Resident Assessment Protocol (RAP) had not been triggered.

An interview with the RAI Coordinator confirmed that the Dental Care RAP was to be triggered and that this assessment had not been completed. The RAI Coordinator confirmed that staff involved in the different aspects of care of the resident had not collaborated with each other so that their assessments were integrated, consistent and complemented each other. (Inspector #214) [s. 6. (4) (a)]

5. The licensee failed to ensure that the Substitute Decision Maker(SDM) of the resident was provided the opportunity to participate fully in the development and implementation of the plan of care. [6(5)]

On an identified date it was noted that resident #300 had a decrease in their appetite and poor intake due to a decline in their health condition. The Registered Dietitian (RD) assessed the resident and ordered a change in the resident's diet texture with additional supplements. The resident's Substitute Decision Maker (SDM) came into visit the resident and was surprised to see that the resident's diet texture had changed as these changes to the resident's diet had not been

discussed with the SDM.

It was confirmed during an interview with the RD on April 6, 2016, that the SDM had not been provided the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

6. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [6(7)]

a) Resident #107 was not provided with care as set out in their plan of care. The resident's plan of care identified a care focus related to restraint/safety and directed staff to ensure the resident's bed was in the lowest position at all times when in bed. Staff #042 and observations made at 1515hrs on April 18, 2016 confirmed that the resident's bed was not placed in the lowest position when the resident was noted to be in bed. (Inspector # 129)

b) A review of resident #101's current written plan of care indicated under nutrition that staff was to provide the resident with a choice of specifically modified fluids at identified intervals daily; provide 125 millilitres of a specifically modified fortified drink at identified intervals and that staff were to provide a specific diet with specifically modified fluids and a number of foods were identified to be provided to the resident.
A review of resident's food and fluid records from April 1-11, 2016, indicated that several entries under the food column for meals and snacks were blank or had a zero (0) amount entered. An interview with PSW #030 indicated that the resident was not provided with the specific diet items identified in the plan of care and that this had been clarified with registered staff #009 approximately one week prior. An interview with the FSNM confirmed that the resident was assessed and that the plan of care from April 1-11, 2016 was accurate based on the assessment of the resident's needs. The FSNM indicated that dietary staff served the meals and nursing staff provided the assistance for eating. An interview with dietary staff #088 on April 12, 2016, confirmed that the resident was only provided with a specifically modified fluid and a modified fortified drink for their breakfast meal on this day.

A review of the resident's snack menu indicated that specific directions related to food were documented in bold letters and in small letters staff were directed about other foods to provide to the resident. An interview with the FSNM indicated that labelled snacks would be implemented and the FSNM confirmed that the care set

out in the residents plan had not been provided to the resident as specified in their plan.

On April 13, 2016, a memo was observed to be posted at the nursing station with a date of April 12, 2016. The memo was titled, "Daily meal/snack pattern" and contained a detailed menu of the items that resident #101 was to receive for each snack and meal time as identified in their written plan of care. (Inspector #214)

c) Resident #300 had a history infections, and on an identified date, the resident's Substitute Decision Maker (SDM) had requested that staff obtain a specific laboratory specimen due to a change in the resident's condition.
Ten days later, the SDM again requested that the specific laboratory specimen be obtained for resident #300 as it had not been obtained after the initial request.

A review of the resident's clinical health record indicated that the Physician had signed the home's medical directive which included an order to obtain this specific laboratory specimen, using a specific method under an identified situation for residents.

Resident #300 demonstrated the identified situation described in the above noted medical directives signed by the Physician. The identified specimen was not obtained until 42 days after the SDM had originally requested the laboratory specimen be obtained and while obtaining the specimen staff had not followed the specific directions contained in the medical directives for obtaining the specimen and the specimen was contaminated.

This specimen confirmed that the resident had an infection and four days later the Physician ordered an antibiotic to be taken for five days.

After the completion of the antibiotics, the resident continued to exhibit symptoms of confusion, lethargy, decreased appetite and behavioural changes and on an identified date, family requested that the home send the resident to hospital due to their condition.

The resident was transferred to hospital and was hospitalized for five days due to this infection, dehydration and other complications.

It was confirmed by the DOC during an interview on April 7, 2016, that care set out in the plan of care was not provided to resident #300 as specified in the plan of

care.

PLEASE NOTE: This area of non-compliance was identified during a complaint inspection, log #020583-15, conducted concurrently during this inspection. (Inspector # 508) [s. 6. (7)]

7. The licensee failed to ensure that the resident was reassessed at least every six months and at any other time when the resident's care needs change. [6(10)]

a) The licensee failed to ensure that the resident was reassessed and the care plan reviewed and revised at least every six months.
Resident #108, staff and the clinical record confirmed that the resident used a restraining device as a personal assistive services device (PASD) for positioning control. The RAI Coordinator confirmed that the home used an assessment tool identified as "Safety Assessment-fall, restraint and bed rail" which was located in the assessment tab of the computerized clinical record to assess residents who fall, are being restrained, use bed rails or use a PASD. The RAI Coordinator confirmed that the above noted assessment completed on September 26, 2017, January 10, 2016 and March 31, 2016 did not indicate that the resident used a restraining device for positioning control and there was no indication that the ongoing need for this PASD and any potential risks associated with its use had been reassessed during this six month period of time. (Inspector # 129)

b) The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed. [6(10)(b)]

(i) On March 1, 2015, resident #304 was witnessed by staff to lean over and inappropriately touch resident #305's.

The staff member intervened, separated the residents and removed resident #305 from the area. A review of resident #305's clinical record indicated that resident #305 had severe cognitive impairment and was not capable of consenting to inappropriate touching.

The Critical Incident report submitted by the home on March 2, 2016, had indicated that their long term action plan was to ensure that these two residents would not be seated in close proximity of each other to minimize a recurrence.

The resident's plan of care that staff refer to for direction in providing care to

residents was not revised with this intervention. There was also no revision in the resident's responsive behaviour plan of care to indicate that resident #304 had the potential for inappropriate touching co-residents.

It was confirmed by the DOC during an interview on April 22, 2016, that resident #304's plan of care was not reviewed and revised when the resident's care needs changed.

PLEASE NOTE: This area of non-compliance was identified during a Critical Incident inspection, log #003651-15, conducted concurrently during this inspection. (Inspector # 508)

(ii) A review of the Critical Incident (CI) report submitted by the home on September 4, 2014, indicated that on an identified date, resident #302 inappropriately touched resident #303.

Resident #303 did not consent to the touching and staff who witnessed the incident immediately separated the residents and reported the incident to the registered staff.

Under the section IV of the CI, titled, Analysis and follow-up, the home indicated that immediate actions taken to prevent a recurrence of the incident was that recreation staff were made aware not to seat the two residents near one another for group activities and that this would be added to resident #303's plan of care.

A review of resident #303's plan of care indicated that the plan had not been updated with this intervention.

It was confirmed by the Programs Manager during an interview on April 15, 2016, that the plan of care for resident #303 had not been reviewed and revised when the resident's care needs changed.

PLEASE NOTE: This area of non-compliance was identified during a Critical Incident inspection, log #004632-14, conducted concurrently during this inspection. (Inspector # 508)

(iii). A review of the wound care assessments for resident #106 indicated that the resident had developed a wound on an identified body part.

A review of the resident's plan of care between October, 2015, and January, 2016, indicated that the resident had a plan of care focus related to skin integrity. The interventions identified that the resident had a wound on another identified body part that was different from the wound identified above.

The plan of care had not been updated when it had been identified that the resident developed a new wound.

It was confirmed during an interview with staff #015, on April 13, 2016, that when the resident was assessed the plan of care was not reviewed and revised when the resident's care needs changed.(Inspector # 508)

(iv) A review of the Minimum Data Set (MDS), dated November 11, 2015, under section I - Disease Diagnosis, indicated that resident #107 had a diagnosis of a respiratory infection.

Further review of the clinical record indicated that the resident had been diagnosed with respiratory infections in two identified months in 2015 and one identified month in 2016.. The resident was treated with antibiotics and staff assessed the resident during the course of the treatments.

A review of the resident's plan of care indicated that the resident's plan had not been reviewed and revised when the resident was diagnosed and treated for these respiratory infections.

It was confirmed by the RAI Coordinator during an interview on April 13, 2016, that the resident's plan of care was not reviewed and revised when the resident's care needs changed. (Inspector # 508)

(v) Resident #104 started exhibiting symptoms of a Upper Respiratory Infection (URI) on an identified date, and was started on antibiotics three days later. The resident's condition continued to decline until their death 11 days later.
A review of the resident's clinical record indicated that when the resident's condition changed, the resident's plan of care had not been revised.

It was confirmed by the RAI Coordinator on April 12, 2016, that the resident #104's plan of care was not reviewed and revised when the resident's care needs changed. (Inspector # 508)

(vi) Resident #109's plan of care was not reviewed or revised when the resident's care needs changed in relation to the demonstration of responsive behaviours. The resident's plan of care for the management of an identified visual deficit directed staff to place utensils within the resident's line of vision and within reach. During observation on March 29, 2016, it was noted that the resident's utensils were not within reach of the resident. At this time personal support staff indicated that the resident was not provided with any utensils because the resident demonstrated responsive behaviours. The DOC, PSW staff # 047 and PSW staff #049 confirmed that the plan of care had not been updated and that the resident was not provided with any utensils due to responsive behaviours the resident demonstrated. (Inspector #129)

(vii) A review of resident #102's written plan of care dated April 5, 2016, indicated under oral care interventions with a revised date of April 9, 2015, indicated that staff were to apply toothpaste to the residents toothbrush and the resident will attempt to brush their teeth. Interventions also included that staff would provide the resident with diluted mouth rinse for them to rinse their mouth.

An interview with PSW # #071 confirmed that a toothbrush and toothpaste were not used as part of the resident's oral care supplies and that only a toothette/swab is used followed by mouthwash and that this has been in place "forever".

An interview with the DOC confirmed that the plan of care was not reviewed and revised when the resident's care needs changed. (Inspector #214)

(viii) A review of a Critical Incident Submission (CIS) that was completed by the home indicated that on an identified date while staff were assisting resident #404 to transfer from their bed to their chair using a mechanical lift, the resident became weak, resulting in a fall onto the floor. The resident sustained two injuries as a result.

A review of the resident's clinical records indicated that they returned back to the home from hospital on an identified date and that a lift and transfer assessment had been completed on this date and the resident was determined to need the use of a total mechanical lift for all transfers.

A review of a Physiotherapy assessment completed in the computerized record indicated that the Physiotherapist (PT) assessed the resident following their return from hospital. The assessment indicated that the resident was weight bearing as

tolerated as per their hospital orders and that during this assessment, the resident complained of pain and was not up to trying to stand due to pain.

An interview with the Physiotherapist confirmed that the resident was unable to stand when conducting their assessment and that the resident's plan of care was not revised for approximately five weeks following the resident's change in their care needs.

PLEASE NOTE: The above noted non-compliance was identified while conducting a Critical Incident System (CIS) Inspection #025842-15, concurrently with this inspection. (Inspector #214) [s. 6. (10)]

8. . [s. 6. (10)]

9. The licensee failed to ensure that when the plan of care was revised because care set out in the plan had not been effective different approaches were considered in the revision of the plan of care. [6(11)(b)]

Resident #107 was observed during this inspection to have bruising on two identified locations.

Documentation in the resident's clinical record indicated that the resident regularly sustained bruises to one of the identified locations and had also had a previous incident of bruising to second identified location. This information was confirmed by the resident's Substitute Decision Maker (SDM) during an interview and confirmed by staff #071.

Staff #071 indicated that resident #107 demonstrated responsive behaviours when care was being provided.

During an interview with the DOC on April 25, 2016, the DOC stated that after assessing the bruise on the second identified area, that it was highly likely that this was a result of an injury sustained during transfer.

The resident's plan of care for transfers was revised in March, 2016; however different approaches had not been considered to minimize the risk of injury to resident #107. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 003, 004, 005, 006 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A1)The following order(s) have been amended:CO# 003,004,005,006

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the licensee achieves compliance in accordance with s. 6(2), s. 6(4) (a) and s. 6 (11) (b), to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident’s health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with a weight change of five percent of body weight or more, over one month; 7.5 percent of body weight or more, over three months and 10 percent of body weight, or more over six months, were assessed using an interdisciplinary approach, and that actions were taken and

outcomes were evaluated.
a) Resident #109's plan of care indicated the resident was at high nutritional risk. The resident experienced a significant weight change over a one month, three month and six month period of time and this weight change was not assessed. Staff and the clinical record confirmed that following the recording of the resident's weight on an identified date as 32.4 kilograms, a computer generated flag which alerted staff the resident had experienced a 5.3 percent weight loss over one month, an 8.7 percent weight loss over three months and a 12.19 percent weight loss over six months. The Director of Care (DOC), the Resident Assessment Instrument (RAI) Coordinator, the Registered Dietitian (RD) and the clinical record confirmed that nursing staff and dietary staff did not respond to the alert notifying them the resident had experienced a significant weight loss. The above noted staff also confirmed that the resident had not been assessed, and actions were not taken to manage the identified weight loss up to and including the time of this inspection. (Inspector #129)

b) Resident #107's plan of care indicated the resident was at moderate nutritional risk. The resident experienced a significant weight loss of 6.4% over a one month period of time in the fall of 2015. A Resident Assessment Protocol (RAP) completed at that time confirmed the resident had experienced a significant weight loss over one month, however; no actions were taken to manage this weight loss. Resident #107 continued to experience weight loss and the following month the clinical record confirmed that the resident had experienced an 8.6 percent weight loss over a three month period of time. The RD and clinical documentation confirmed that this weight change was not assessed and actions were not taken to manage this ongoing weight loss. (Inspector #129)

c) A review of resident #101's documented weights in the clinical record indicated that over a one month period of time in the winter of 2016 the resident experienced a weight loss of 5.8 per cent. The following month the clinical record indicated the resident had experienced an 8.4 per cent weight loss over a three month period of time and the following month the clinical record indicated the resident had experienced a 17.6 per cent weight loss over a six month period of time. The clinical record indicated that no assessments had been completed when the resident was identified as having experienced a 5.8 percent weight loss over one month, a 8.5 percent weight loss over three months or a 17.6 percent weight loss over six months.

An interview with the RD confirmed that the resident was not assessed when they

demonstrated the weight changes noted above. (Inspector #214) [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

CO # - 007 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that staff complied with the home’s policy “Pain Management”, identified as #CN-P-09-1 and dated January 2016.

Resident #302 had a fall which resulted in an injury on an identified date. The resident was treated in hospital and returned to the home.
A review of the home's policy #CN-P-09-1, Pain Management, dated January, 2016, under the procedures to manage residents for pain, indicated that the interdisciplinary team will assess residents for pain upon re-admission, quarterly or change in condition that impacts pain or causes new pain or if the resident indicates ongoing unrelieved pain.

A review of the resident's clinical health record indicated that the resident was not reassessed upon the re-admission. Records indicated that the resident's pain assessment had not been conducted until 12 days after the resident was re-admitted.
It was confirmed by the Director of Care during an interview on April 8, 2016, that the home's Pain Management policy was not complied with. (Inspector # 508)

2. The licensee failed to ensure that staff complied with the home's policy "Skin Care and Wound Care", identified as #CN-S-13-3 and dated November 2015.

Resident #105 had a fall on an identified date that resulted in an injury. The resident received treatment in hospital and returned to the home.
A review of the home's Skin Care and Wound Care policy #CN-S-13-3, dated November, 2015, under the skin assessment section, directed staff to complete a skin assessment upon admission, quarterly, upon return from hospital and upon return from leave of absence (LOA) greater than 24 hours using the Skin and Risk Assessment Tool.
A review of the resident's clinical record indicated that staff did not complete this assessment when the resident returned from the hospital.
It was confirmed by the Resident Assessment Instrument (RAI) Coordinator during an interview on April 7, 2016, that staff had not complied with the Skin and Wound Care policy. (Inspector # 508)

3. The licensee failed to ensure that staff complied with the home's protocol to assess a resident who has fallen for injury prior to moving them. This protocol was identified by the Director of Care (DOC).
Resident #105 experienced an unwitnessed fall on an identified date. This incident was reported to the Registered Nurse (RN) by a PSW who found the resident. A review of the resident's clinical record indicated that the resident complained of extreme pain and was demonstrating a behaviour that would suggest pain was being experienced.
Three staff members lifted the resident from the floor and put the resident into bed to do an assessment. The resident was assessed and transferred to hospital where it was confirmed that the resident had sustained an injury.
During an interview with the DOC, the DOC had indicated that the home's protocol for when a resident is found on the floor, was that the resident is not moved until an assessment had been conducted.
It was confirmed by the DOC during an interview on April 13, 2016, that the protocol to assess residents when residents are found on the floor post fall was not

complied with. (Inspector # 508)

4. The licensee failed to ensure that staff complied with the home's policy "Weight Change Policy" identified as #CN-W-04-1 and dated August 2010.
This policy directed that, every resident will be weighed monthly and the weight will be recorded in the weight book. Any resident with a significant weight change of 5% in one month, 7.5% over 3 months, 10% over 6 months will be reweighed by nursing staff as soon as possible after the noted weight change is recorded. If there is a significant weight change or if there is any other weight change that compromises the resident's health status the FSNM and Registered Dietitian will be notified to intervene. The Registered Dietitian will chart what actions will be taken, update the care plan and evaluate the outcomes.

a) Clinical documentation confirmed that resident #101 experienced a 5.8 percent weight loss over a one month period of time in the winter of 2016. an 8.4 percent weight loss over a three month period of time the following month and a 17.6 percent weight loss over a six month period of time. An interview with registered staff #011 indicated that nursing staff documented residents weight on a paper form titled, "Weights for Residents". These weights were then entered in the computerized clinical record system and any resident's requiring re-weights would have their names listed on a sheet of paper that was kept at the nursing station. Staff #011 indicated that the re weights were not entered into the resident's clinical record and that the sheet containing re weights was given to the RD. A review of the resident's clinical record including the weight tab in computerized record indicated that no re-weights for the time periods above when the resident demonstrated a significant weight loss, could be located. An interview with the DOC confirmed that the only re-weight that was able to be located for resident #101 was completed in the month of was not completed following the above mentioned weight loss. An interview with the DOC confirmed that the home's policy with regards to weight change had not been complied with.
Registered staff #011 indicated that referrals to the RD were completed via a paper referral or an electronic referral in the computerized clinical record. A review of resident #101's clinical record indicated that no paper or electronic referrals to the RD could be located to address the significant weight loss the resident had experienced. An interview with the FSNM confirmed that no referrals with regards to the resident's significant weight loss could be located when it was identified that the resident experienced a 5.8 percent weight loss over a one month period of time, an 8.4 percent weight loss over a three month period of time and a 17.6 percent weight loss over a six month period of time. An interview with the DOC

confirmed that the home's policy with regards to weight change had not been complied with. (Inspector #214)

b) Clinical documentation confirmed that resident #109 experienced a 5.3 percent weight loss over one month in the winter of 2016. The DOC, FSNM and the clinical record confirmed that nursing staff did not re-weigh resident #109 when it was identified that the resident has experienced a significant weight loss of 5.3 percent over a one month period of time.
The DOC, FSNM, RD and the clinical record confirmed that when it was identified that resident #109 had experienced a significant weight loss of 5.3 percent over a one month period of time the FSNM and the RD were not notified of this significant weight change and no actions were taken to address this significant weight change.
The DOC, FSNM, RD and the clinical record confirmed that when it was identified that resident #109 had experienced a significant weight loss of 5.3 percent over a one month period of time the FSNM and the RD were not notified of this significant weight change and no actions were taken to address this significant weight change. (Inspector #129)

c) The DOC, FSNM, RD and the clinical record confirmed that when it was identified that resident #107 had experienced an 8.6 percent weight loss over a three month period, this significant weight change was not assessed and actions were not taken to manage the resident's weight loss. (Inspector #129)

5. The licensee failed to ensure that staff complied with the home's policy "Safe Resident Handling Policy", identified as #CHS-1-20-1 with a revision date of March 2016.
A review of a Critical Incident Submission (CIS) that was completed by the home indicated that on an identified date indicated that while resident #404 was being assisted by staff to transfer from their bed to their chair using a mechanical lift they became weak, fell and sustained an injury.
The CIS indicated that the resident had a lift and transfer assessment completed 12 days prior to this incident. A review of the resident's assessments in the computerized record indicated that a Lift and Transfer assessment had been completed in the winter of 2015 and not again until after the resident returned from hospital following the above noted incident. The lift and transfer assessment that was identified in the CIS was titled, "Re-admission-V1" and dated August 17, 2015, and completed following the resident's return from a hospitalization related to a medical condition. A review of this assessment indicated under transfer device that

a check mark had been placed beside both a total mechanical lift and another lift and had not included any other information as to how the assessor determined the use of these lifts.
A review of the home's policy, titled, "Safe Resident Handling Policy" (CHS-1-20-1 with a revision date of March 2016), indicated the following:
i) that all staff conduct a mobility review using the C.A.R.E. module tool on all residents prior to initiating any lift or transfer.
ii) the assessment for lifts and transfers will be reviewed and updated a minimum of quarterly and as required.
iii) Mede-care specific requirement.
An interview with the DOC and RAI Coordinator confirmed that they were not aware of the C.A.R.E. module tool that is to be used on all residents prior to initiating any lift or transfer and confirmed that the home no longer used the requirements identified in the policy because they had changed their computerized record system. The DOC and RAI Coordinator confirmed that a lift and transfer assessment had not been completed quarterly or upon the resident's return from hospital and that the home had not complied with their policy.
PLEASE NOTE: The above noted non-compliance was identified while conducting a Critical Incident System (CIS) Inspection #025842-15, concurrently with this inspection. (Inspector #214)

6. The licensee failed to ensure that staff complied with the home's policy ""Height", identified as #CN-H-09-1 and dated March 28, 2011.
A review of the home's policy titled, "Height" (CN-H-09-1 and dated March 28 2011) indicated the following:
i) Every resident admitted into facility must have their height recorded within 24 hours of admission.
The Ontario Regulation 79/10, [r.68 (2) (ii)], indicates that the licensee shall ensure that the nutrition care and hydration programs include body mass index and height upon admission and annually thereafter.
An interview with the DOC on April 14, 2016, confirmed that this was the only policy the home had with regards to height and that this policy had not been in compliance with all applicable requirements under the Act. (Inspector #214)

7. The licensee failed to ensure that staff complied with the home's "Weight Review" procedure identified as CD-05-28-1, dated June 2010 and located in the Dietary Manual. This procedure directed that the "resident's weight is documented on the identified form; staff completing this document were to determine if the weight loss or gain documented was significant according to the formula included

in the procedure, if the weight change was identified as significant staff were to complete a Nutritional Referral and forward it to the Registered Dietitian (RD)".
Staff did not comply with this direction when:
Clinical documentation indicated that following the recording of the resident #109's weight on an identified date as 32.4 kilograms, a computer generated flag alerted staff the resident had experienced a 5.3 percent weight loss over one month, a 8.7 percent weight loss over three months and a 12.19 percent weight loss over six months. The Director of Care (DOC), the Food Services and Nutrition Manager (FSNM) as well as the RD confirmed that staff did not use the Weight Review form included in the above noted policy and a referral to the RD was not completed when it was identified in the computerized clinical record that resident #109 had experienced the above noted significant changes in their weight. (Inspector #129)

8. The licensee did not ensure that staff complied with the home's "Weight Scale and Weighing Residents" procedure, identified as CN-W-02-1, dated August 2010 and located in the Nursing Manual.

a) This procedure directed that "registered staff were to review resident's weights for significant discrepancies and if a discrepancy was noted then registered staff were to re-weigh the resident". The DOC, FSNM, Resident Assessment Instrument (RAI) Coordinator and the clinical record confirmed that staff did not comply with this direction when registered staff entered a weight for resident # 109 in the computerized record on an identified date but did not obtain a re-weight for this resident even though when the weight was entered a flag was generated indicating the resident had lost 1.8 kilograms which represented a 5.3 percent weight loss since the weight identified the month previous. (Inspector #129)

b) This procedure directed that "should the resident's weight fluctuate to a significant degree, registered staff were to notify the FSNM and follow the weight change policy". The DOC, FSNM and the clinical record confirmed that the staff did not comply with this direction when the FSNM was not notified that resident #109 had lost 5.3 percent of their weight over one month which was identified as a significant weight loss. (Inspector #129)

9. The licensee failed to ensure that staff complied with the home's "Dietitian Consultation" procedure, identified as CN-D-06-1, dated April 2011 and located in the Nursing Manual. This policy directed that "in order to determine the cause and to rectify an unexplained weight change of five percent or more of body weight over one month, 7.5 percent or more over 3 months or 10 percent or more in 6 months –

nursing will notify FSNM of the need for Dietitian consult and FSNM will notify the Dietitian directly". The FSNM and the RD confirmed staff did not follow this direction when nursing staff did not notify the FSNM that resident #109 was identified as having experienced a 5.3 percent weight change over a one month period of time. (Inspector #129)

10. The licensee failed to ensure that staff complied with the home's "Restraints" policy, identified as CN-R-05-1, dated December 2015 and located in the Nursing Manual. This policy directed that "staff apply the physical device in accordance with any manufacturer's instructions". Registered staff #009 and Personal Support Worker (PSW) # confirmed on March 31, 2016, when it was identified that resident #109 had a restraining device applied and that the device had not applied correctly. On the above noted date it was observed that the restraining device had been engaged and there was a 14 inch gap between the device and resident #109's body. At the time of this observation staff in attendance confirmed that they were aware that the restraining device had not been applied according to manufactures directions. (Inspector #129)

11. The licensee failed to ensure that staff complied with the home's procedure for cleaning and disinfecting the whirlpool lift chair. The home posted a procedure on the wall beside the whirlpool that directed staff to "spray and scrub all surfaces which have been lowered into water - make sure you wash all undersides as well". Staff did not comply with this direction when during a tour of the home on March 29, 2016 it was observed and confirmed by the RAI Coordinator that the underside of the whirlpool lift chair was heavily soiled with a white substance. (Inspector #129)

12. The licensee failed to ensure that staff complied with the home's policy "Bed Rail-Safe Use and Entrapment Risk Management" identified as CN-B-08-1 and dated September 2014. This policy directed that "Low air loss surfaces are exempt from the Health Canada Guidelines but risks for entrapment exist and need to be mitigated. Potential solutions include: bolsters and pillows to support the resident, pool noodles between the mattress and the rails, bed rail pads and mattress solution strategies". Staff did not comply with this direction when it was confirmed by the Environmental Supervisor that following the completion of a "Bed/Entrapment Audit" on March 10, 2016 the report indicated that an identified bed system had failed entrapment testing because the mattress on the bed frame was a low air loss mattress and that no actions were taken mitigate the risk of entrapment for the resident using this bed system. (Inspector #129) [s. 8. (1) (b)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 008

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.
Valley Park Lodge is a licensed 65 bed home. The Assistant Administrator and the staffing schedule confirmed that there was not a registered nurse who was both an employee of the licensee and a member of the regular nursing staff on duty in the home on the evening shift of March 17, 2016.

(PLEASE NOTE: the above noted findings were identified during the inspection of Complaint log # 009330-16) [s. 8. (3)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

On an identified date, staff witnessed resident #302 inappropriately touch resident #303, which had been confirmed as non-consensual touching on the date of the incident.

The home’s policy titled, Abuse-Prevention, Reporting and Elimination of Abuse and Neglect, #CA-05-37, dated June, 2010, under procedures and interventions for when abuse/neglect was alleged, suspected or witnessed, indicated that any person who suspected that abuse or neglect had occurred must report it to the registered staff who follow the steps as if the abuse/neglect was witnessed. Registered staff must contact the Administrator and or designate immediately for direction. The Administrator and or delegate must notify the Ministry of Health and Long Term Care (MOHLTC) by phone immediately to report that an alleged, suspected or witnessed abuse or neglect has taken place or is likely to have taken place in accordance with the Long Term Care Homes Act (LTCHA) and the reporting policy.

A review of the Critical Incident report submitted by the home indicated that the home notified the Ministry of Health and Long Term Care (MOHLTC) ten days after the incident, and did not call the MOHLTC immediately to report this incident.

The policy also indicated that abused residents will be offered counselling and support services from management, staff and or chaplain.

A review of the resident’s clinical health record indicated that these services had not been offered to the resident.

It was confirmed by the DOC during an interview on April 22, 2016, that the written policy to promote zero tolerance of abuse and neglect of residents was not complied with.

PLEASE NOTE: This area of non-compliance was identified during a Critical Incident inspection, log #004632-14, conducted concurrently during this RQI. [s. 20. (1)]

Additional Required Actions:

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

WN #8: 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:
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of communication abilities and language. [26(3) 3)] Resident #109's plan of care related to communication abilities and language was not based on an interdisciplinary assessment. The resident's plan of care indicated the resident had cognitive diagnosis and a language barrier which affected the resident's ability to effectively communicate. An intervention put in place to address this care focus was that staff who speak the same language as the resident would translate communication. Personal support staff # 047 and #049 confirmed that they are not sure if the resident understands communication in their first language based on the resident's cognitive diagnosis. The Director of Care (DOC) confirmed that they did not believe the resident was able to comprehend communication spoken in their first language due to a worsening of the resident's cognitive diagnosis and that the resident's communication abilities had not been assessed prior to, or subsequent to the above noted interventions being placed in the residents care plan. (129) [s. 26. (3) 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 and ensuring that the plan of care is based on, at a minimum, interdisciplinary assessment of communication abilities, language and special treatments and interventions, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

a) A review of resident #100's written plan of care under interventions in place for oral care and dated with a revised date of April 14, 2015 as well as the quarterly Resident Assessment Protocol (RAP) for Dental Care dated September 19, 2015, indicated that the resident required the assistance of one staff twice daily to provide assistance with their oral care needs. A review of the PSW Flow Sheets which staff used to document the care provided to the resident was conducted from September 20 – 30, 2015. Documentation under Dentures and Oral Care indicated that oral care was documented as being provided only once daily on September 22, 27, 28, 29 and 30, 2015. A review of the resident's clinical record including progress notes from September 20-30, 2015, had not included any documentation of the resident refusing oral care on the dates reviewed.

An interview with the DOC and the RAI Coordinator confirmed that oral care was documented as only being provided once daily on the identified dates and no documentation was included to indicate that the resident refused. The DOC and RAI Coordinator confirmed that not all actions taken with respect to resident #100's oral care were documented. (Inspector #214) [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 and ensuring that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions were documented, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who exhibited altered skin

integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.[50 (2) (a) (ii)]

Resident #302 had a fall with injury on an identified date. The resident was transferred to hospital for treatment and returned to the home. A review of the resident's clinical health record indicated that staff had not conducted a skin assessment upon return from the hospital or at any time after the resident was re-admitted back to the home regarding the management of skin integrity issues that resulted from the injury.

It was confirmed by the documentation and the Director of Care during an interview on April 7, 2016, that this resident who exhibited altered skin integrity did not received a skin assessment by a member of the registered nursing staff upon any return from hospital.

PLEASE NOTE: This area of non-compliance was identified during a complaint inspection, log# 020583-15, conducted concurrently during this Resident Quality Inspection. [s. 50. (2) (a) (ii)]

2. The licensee failed to ensure that a resident that exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [50 (2) (b) (i)]

During resident observation by Inspector #129 on March 31, 2016, at 1016 hours, the Inspector identified that resident #109 had several bruises covering three identified areas. A review of the resident's clinical record in the progress notes dated April 7, 2016, indicated that a Personal Support Worker (PSW) reported to staff #027 that the one of these areas was swollen. It was also documented that there was discolouration on one of the other identified area as well as another area not previously identified.

On April 19, 2016, resident #109 was observed by Inspector #508 to have bruising on one new area and one previously identified area. A review of the resident's clinical record indicated that a skin assessment had not been completed related to any of these alterations in skin integrity.

It was confirmed by the DOC during an interview on April 20, 2016, that the

resident had not received a skin assessment by a member of the registered staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment when the resident had an alteration in their skin integrity. [s. 50. (2) (b) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that a resident who exhibited altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital., to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #105 experienced a fall on an identified date that resulted in an injury for which the resident was treated in hospital and then returned to the home.

The resident was assessed upon return from the hospital and it was identified that the resident’s pain was controlled at the time of re-admission. Three days later the resident complained of pain and had requested pain medication, however, the resident had already been given pain medication and had to wait to receive another dose.

A review of the resident’s clinical record indicated that the resident had requested additional pain medication in addition to their regularly scheduled medication on two other identified dates, however, no pain assessments were conducted.

It was confirmed by the DOC during an interview on April 14, 2016, that a pain assessment using a clinically appropriate assessment instrument specifically designed for this purpose was not conducted when the resident’s pain was not relieved by initial interventions. [s. 52. (2)]

Additional Required Actions:

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

WN #12: The Licensee has failed to comply with 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 that, for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours. [53(4)(b)]

Resident #109 demonstrated three identified responsive behaviours. The resident also had a language barrier and could not communicate with staff and co-residents.

The resident was observed during this inspection on April 8, 12, 13 and 14, 2016, to be demonstrating two of the identified responsive behaviours. It was observed by the Inspector on these identified dates that the resident was moved to other areas of the facility when the resident exhibited these behaviours.

A review of the resident's psychosocial well-being plan of care indicated that an intervention in the resident's plan included taking resident #109 to a specifically area of the building and attempt to hold their attention with specifically identified objects and activities.

Staff interviewed on April 14, 2016, indicated that the specific area was not set up due to an environmental hazard and therefore the home did not have a this area anymore for resident #109 to be taken to.

Staff #078 confirmed during an interview on April 14, 2016, that the strategies that were developed to respond to resident #109's responsive behaviours were not implemented. (Inspector #508) [s. 53. (4) (b)]

2. The licensee failed to ensure that for each resident demonstrating responsive behaviours, that 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. [53(4)(c)]

a) A review of resident #101's quarterly Minimum Data Set (MDS) coding for section E.-Mood and Behaviour Patterns and dated December 12, 2015, indicated that the resident was coded as demonstrating a responsive behaviour that was not easily altered. A review of the PSW Flow Sheet record from December 6 – 31, 2015, indicated that the resident demonstrated the identified behaviour on 53 occasions during this time period and that 23 of these times, the behaviour was not easily altered. A review of the resident's progress notes from December 6-31, 2015, indicated that no documentation was included regarding the resident demonstrating this behaviour; when this behaviour was demonstrated; what actions had been taken to respond to the needs of the resident or the resident's response to any interventions that were implemented, for the documented incidents identified on the PSW Flow Sheets.

An interview with the RAI Coordinator confirmed that the resident did demonstrate the identified responsive behaviour and that actions taken to respond to the needs of the resident, including assessments, reassessments and interventions and the resident's responses to interventions had not been documented. (Inspector #214)

b) A review of a Critical Incident Submission (CIS) that was completed by the home indicated that on an identified date, resident #403 was observed to have inappropriately touched #404. A review of resident #403's clinical record indicated that documentation recorded for this incident had not included details of this incident regarding what had occurred; who was involved; where the incident took place and what persons if any, had observed the incident. The documentation had not included what immediate actions were taken by staff to respond to the needs of the resident or the resident's responses to any interventions.

An interview with the DOC confirmed that resident #403 had known responsive behaviours of inappropriate touching and that actions taken to respond to the needs of the resident, including assessments, reassessments and interventions

and the resident's responses to interventions had not been documented for this incident.

PLEASE NOTE: The above noted non-compliance was identified while conducting a Critical Incident System (CIS) Inspection #001584-15, concurrently with this RQI.
(Inspector #214) [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours and actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the Nutrition care and hydration programs include,(ii) body mass index and height upon admission and annually thereafter.

During stage one of the Resident Quality Inspection (RQI), census record reviews conducted indicated that not all resident's height's had been obtained on an annual basis. A review of resident #102's clinical record indicated that their last documented height was on March 28, 2008. Resident #109's last documented height was on December 30, 2005 and resident #401's last documented height was on April 30, 2010.

An interview with the Registered Dietitian on April 13, 2016, confirmed that not all resident's had their heights measured and documented on an annual basis. [s. 68. (2) (e) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the Nutrition care and hydration programs include,(ii) body mass index and height upon admission and annually thereafter, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provide direct care to residents received as a condition of continuing to have contact with residents, annual retraining in accordance with O. Reg. 79/10, s. 219(1), in relation to the following: [76(7)]

a) The licensee failed to ensure that all staff who provided direct care to residents received annual retraining in the area of abuse recognition and prevention. [76(7)1]

The Assistant Administrator confirmed that 90 staff were employed by the home. Training documents for 2015, including sign in sheets, provided by the home at the time of this inspection indicated that 22 out of 90 staff had not received training in the area of, abuse recognition and prevention in 2015. (Inspector # 508)

b) The licensee failed to ensure that all staff who provided direct care to residents received annual retraining in the area of behaviour management. [76(7) 3]

The Director of Care confirmed that 71 staff in the home provided direct care to residents. Training documents for 2015 provided by the home at the time of this inspection indicated that 22 of 71 staff had not received training in the area of behaviour management in 2015. (Inspector #214)

c) The licensee failed to ensure that all staff who provided direct care to residents received annual retraining in the area of minimizing restraining of residents and where restraining is necessary, how to do so in accordance with this Act and the regulations. [76(7) 4]

The Director of Care confirmed that 71 staff in the home provided direct care to residents. Training documents for 2015 provided by the home at the time of this inspection indicated that 26 of 71 staff had not received training in the area of, how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the Regulation in 2015. (Inspector #129)

d) The licensee failed to ensure that all staff who provided direct care to residents received annual retraining in accordance with O. Reg. 79/10, s. 219(1) in relation to other areas provided for in the regulations. [76(7) 6]

1. The licensee failed to ensure that all staff who provided direct care to residents received as a condition of continuing to have contact with residents, annual retraining in the area of falls prevention and management, in accordance with O. Reg. 79/10, s 221(1) 1.

The Director of Care confirmed that 71 staff in the home provided direct care to residents. Training documents for 2015 provided by the home at the time of this inspection indicated that 22 of 71 staff had not received training in the area of falls

prevention and management.

2. The licensee failed to ensure that all staff who provided direct care to the residents received as a condition to continuing to have contact with residents annual retraining in the area of skin and wound care in accordance with O. Reg. 79/10, s. 221(1) 2.

The Director of Care confirmed that 71 staff in the home provided direct care to residents. Training documents for 2015 provided by the home at the time of this inspection indicated that 23 of 71 staff had not received training in the area of skin and wound care in accordance with O. Reg. 79/10, s. 221(1)2. (Inspector #508)

3. The licensee failed to ensure that all staff who provided direct care to the residents received as a condition to continuing to have contact with residents annual retraining in the area of continence care and bowel management, in accordance with O. Reg. 79/10, s. 221(1) 3.

The Director of Care confirmed that 71 staff in the home provided direct care to residents. Training documents for 2015 provided by the home at the time of this inspection indicated that 21 of 71 staff had not received training in the area of continence care and bowel management. (Inspector #508)

4. The licensee failed to ensure that all staff who provided direct care to the residents received as a condition to continuing to have contact with residents annual retraining in the area of pain management, including pain recognition of specific and non-specific signs of pain, in accordance with O. Reg. 79/10, s. 221(1) 4.

The Director of Care confirmed that 71 staff in the home provided direct care to residents. Training documents for 2015 provided by the home at the time of this inspection indicated that 22 of 71 staff had not received training in the area of pain management, including recognition of specific and non-specific signs of pain. (Inspector # 508) [s. 76. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that annual retraining is provided in accordance with s. 76(7) and associated regulations., to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the written staffing plan was evaluated and updated at least annually.

The Assistant Administrator contacted the Administrator by telephone who confirmed that the home had not completed an annual evaluation for 2015 of the written staff plan.

(PLEASE NOTE: the above noted findings were identified during the inspection of Complaint log # 009330-16) [s. 31. (3) (e)]

WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents’ Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents’ Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents’ Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that if the Residents’ Council had advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents’ Council in writing.

A review of the Residents’ Council meeting minutes from October 2015 – March 2016, was conducted. The October 8, 2015, meeting minutes indicated that the council made a recommendation for a towel warmer to be purchased for use in the shower room for the cooler months. A review of the minutes indicated that a response in writing within 10 days of receiving this recommendation could not be located. An interview with the president of the Residents’ Council confirmed that they could not recall receiving a response to this recommendation and assumed it was due to costs. An interview with the Director of Therapeutic Recreation Services who completes the minutes for the Residents’ Council indicated that they were not present for this meeting and that a response in writing within 10 days of this recommendation was unable to be located. [s. 57. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that within 10 days of becoming aware of the incident, or sooner when required by the Director, made a report in writing to the Director that set out the following with respect to the incident:
v. the outcome or current status of the individual or individuals who were involved in the incident.

On an identified date, resident #302 was witnessed to inappropriately touch resident #303, which was confirmed as non-consensual touching.

The Critical Incident (CI) report submitted by the home on 10 days after the incident, did not provide the outcome or current status of the individuals involved in the incident. A request had been sent to the home to update the report to amend the (CI) report with this information; however, the report had not been amended.

It was confirmed by the RAI Coordinator during an interview on April 13, 2016, that this report had not been amended to provide the Director with the outcome or current status of the individual or individuals who were involved in the incident. [s. 107. (4) 3. v.]

WN #18: 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. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident is restrained by a physical device under section 31 or section 36 of the Act that staff apply the physical device in accordance with any manufacturer's instructions. [110(1)1]
A restraining device that was noted to be used for resident #109's was not applied according to manufacturer's direction. Manufacturer's directions for the specific restraining device used provided by the home at the time of this inspection directed that "when properly adjusted and the and tightened, the device it should fit snug so that the resident's body part is secure". On March 31, 2016 at 0950 the resident was noted to have the identified restraining device applied and at that time it was noted that there was a 14 inch gap between the resident's body and the device. Registered staff #009, who was in attendance at the time and personal support worker (PSW) #070 who was assigned to provide care to the resident confirmed that the device had not been applied correctly in accordance with the manufacturer's directions. [s. 110. (1) 1.]

2. The licensee failed to ensure that for every use of a physical restraint all reassessments, including the resident's response were documented. [110 (7) 6]
Resident # 109's plan of care directed that staff were to apply a restraining device to the resident under specific circumstances. Registered staff #001 and the clinical record confirmed that a reassessment completed on January 17, 2016 related to the application of the device did not include documentation of the resident's response to the restraining or action taken to determine if the restraining of resident #109 continued to be necessary. (129) [s. 110. (7) 6.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

s. 212. (4) Subject to subsection (5), the licensee shall ensure that everyone hired as an Administrator after the coming into force of this section,
(a) has a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration; O. Reg. 79/10, s. 212 (4).
(b) has at least three years working experience,
(i) in a managerial or supervisory capacity in the health or social services sector, or
(ii) in another managerial or supervisory capacity, if he or she has already successfully completed the course mentioned in clause (d); O. Reg. 79/10, s. 212 (4).
(c) has demonstrated leadership and communications skills; and O. Reg. 79/10, s. 212 (4).
(d) has successfully completed or, subject to subsection (6), is enrolled in, a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time. O. Reg. 79/10, s. 212 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the person acting in the role of the Administrator had successfully completed or was enrolled in a program in long-term care administration or management that was a minimum of 100 hours in duration of instruction time.

During this Resident Quality Inspection (RQI), it had been identified that since February 23, 2016, the position of the Administrator was being filled by the Assistant Administrator (AA) in the absence of the Administrator.

During an interview with the Assistant Administrator on April 8, 2016, it was confirmed that the AA had assumed the role of the Administrator in the home and had not completed or was enrolled in a program in a long-term care administrator or management that was a minimum of 100 hours in duration of instruction. (508)
[s. 212. (4) (d)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 217. The licensee shall ensure that there is a designated lead for the training and orientation program. O. Reg. 79/10, s. 217.

Findings/Faits saillants :

1. The licensee failed to ensure that there was a designated lead for the training and orientation program.

On April 25, 2016 the Director of Care confirmed that there was not a designated lead for the training and orientation program. [s. 217.]

Issued on this 26 day of August 2016 (A1)

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

Original report signed by the inspector.

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : PHYLLIS HILTZ-BONTJE (129) - (A1)

Inspection No. / No de l'inspection : 2016_205129_0005 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 008334-16 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Aug 26, 2016;(A1)

Licensee / Titulaire de permis :
955464 ONTARIO LIMITED
3700 BILLINGS COURT, BURLINGTON, ON,
L7N-3N6

LTC Home / Foyer de SLD :
VALLEY PARK LODGE
6400 VALLEY WAY, NIAGARA FALLS, ON,
L2E-7E3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : JENNIFER ANDERSON

To 955464 ONTARIO 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. Duty to protect

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all residents, including residents #303 and #305, are protected from abuse by anyone and to ensure that all residents are not neglected by the licensee or staff. The plan shall include but not be limited to the following:
1. Mandatory re-education for all staff on the home's Abuse and Neglect policy, #CA-05-37.
2. Education for all relevant staff on the home's resident medical directives, specifically related to infections and on obtaining laboratory specimens.
3. Development and implementation of a system or process to ensure that all resident or Substitute Decision Makers (SDM) requests for resident care are responded to and all actions taken are documented by the appropriate staff.

The plan is to be submitted on or before August 8, 2016 to Phyllis Hiltz-Bontje@Ontario.ca

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (2) and compliance history (2), in keeping with s.299 (1) of the Regulation , in respect of the actual harm that resident #300 experienced, the scope of a pattern of three of three incidents within the context of a Resident Quality Inspection, and the licensee's history of previous non-compliance, unrelated.

2. The licensee failed to ensure that residents were protected from abuse by anyone.

A review of the Critical Incident report submitted by the home indicated that on an identified date, staff #076 witnessed resident #302 inappropriately touch resident #303.
Resident #303 was competent; however, experienced communication difficulties due to health conditions. Staff #076 separated the two residents and asked resident #303 if they felt uncomfortable with resident #302's actions and resident #303 indicated they did.
It was confirmed through documentation and during an interview with the DOC on April 22, 2016, that resident #303 was not protected from abuse by anyone.

3. The licensee failed to ensure that residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff.
Resident #300 had a diagnosis of dementia and a history of recurring infections. The resident had appointed two family members as Substitute Decision Makers (SDM) for health care decisions.
A review of the resident's clinical record indicated that staff had observed and documented that on an identified date, the resident was lethargic, confused and did not "seem them self".

Twenty five days later, the resident complained of pain all over and had requested to go to bed after supper due to not feeling well.

Thirteen days following the above noted incident, family were in to visit resident #300 and had identified that the resident was very confused and reported to staff that the resident could not feed them self and required family assistance for eating, which was not typical for the resident. During this visit the family requested a laboratory specimen be obtained as they suspected the resident had an infection.

Ten days after the SDM had requested a laboratory specimen be obtained and while attending a care conference for resident #300, the SDM again requested that a specimen be obtained as the SDM was still concerned with the resident's decline in their cognitive status and the home had still not obtained the specimen. The SDM also indicated at this meeting that in the past, the resident would exhibit the symptom of cognitive decline when the resident had an infection and would improve when treated with antibiotics.

Four days after the initial request the SDM made a second request to have a specimen obtained, the resident complained of back pain and requested to go to bed

after breakfast. The following day, staff had identified that the resident was weak and could not feed them self. Two days after staff made the above noted observations of the resident, it was identified that the resident was unusually sluggish, slow when responding to questions and not answering questions appropriately.

Two days later, it was again identified by staff that the resident was lethargic and had difficulty swallowing food. Further review of the clinical record indicated that the resident continued to have a decline in their health condition and 18 days later, the resident became anxious and was breathing rapidly. When staff asked the resident why they were breathing that way, the resident responded “if I stop I will die”.

Five days later staff noted that the resident’s condition remained unchanged and staff obtained the specimen that had been requested for the second time by the SDM’s 33 days earlier. Staff did not follow the home's medical directives related to a specific infection and specifically the method of obtaining specimens related to this infection. Staff contaminated the specimen when they did not follow the home's medical directives for obtaining this specimen; however, the specimen confirmed that the resident had an infection and five days later, the Physician ordered an antibiotic to be taken for five days.

After the completion of the antibiotics, the resident continued to exhibit symptoms of confusion, lethargy, decreased appetite and behavioural changes. The clinical record indicated that staff documented two days after the start of the treatment for this infection, 12 days after the start of the treatment and 14 days after the start of the treatment, resident #300 had repeated bouts of emesis and family requested that the home send the resident to hospital due to their condition.
The resident was transferred to hospital and was hospitalized for five days due to this infection, dehydration and other complications.
It was confirmed by the Director of Care (DOC) during an interview on April 7, 2016, that resident was neglected by staff when the home failed to provide the resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction that jeopardized the health, safety or well-being.

PLEASE NOTE: This area of non-compliance was identified during a complaint inspection, log #020583-15, conducted concurrently during this RQI. (Inspector 508)

(508)

2. The licensee failed to ensure that residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff.

Resident #300 had a diagnosis of dementia and a history of recurring infections. The resident had appointed two family members as Substitute Decision Makers (SDM) for health care decisions.
A review of the resident's clinical record indicated that staff had observed and documented that on an identified date, the resident was lethargic, confused and did not "seem them self".
Twenty five days later, the resident complained of pain all over and had requested to go to bed after supper due to not feeling well.
Thirteen days following the above noted incident, family were in to visit resident #300 and had identified that the resident was very confused and reported to staff that the resident could not feed them self and required family assistance for eating, which was not typical for the resident. During this visit the family requested a laboratory specimen be obtained as they suspected the resident had an infection.
Ten days after the SDM had requested a laboratory specimen be obtained and while attending a care conference for resident #300, the SDM again requested that a specimen be obtained as the SDM was still concerned with the resident's decline in their cognitive status and the home had still not obtained the specimen. The SDM also indicated at this meeting that in the past, the resident would exhibit the symptom of cognitive decline when the resident had an infection and would improve when treated with antibiotics.
Four days after the SDM made the second request to have a specimen obtained, the resident complained of back pain and requested to go to bed after breakfast. The following day, staff had identified that the resident was weak and could not feed them self. Two days after staff made the above noted observations of the resident, it was identified that the resident was unusually sluggish, slow when responding to questions and not answering questions appropriately.
Two days later, it was again identified by staff that the resident was lethargic and had difficulty swallowing food. Further review of the clinical record indicated that the resident continued to have a decline in their health condition and 18 days later, the resident became anxious and was breathing rapidly. When staff asked the resident why they were breathing that way, the resident responded "if I stop I will die".
Five days later staff noted that the resident's condition remained unchanged and staff

obtained the specimen that had been requested for the second time by the SDM's 33 days earlier. Staff did not follow the home's medical directives related to a specific infection and specifically the method of obtaining specimens related to this potential infection. Staff contaminated the specimen when they did not follow the home's medical directives for obtaining this specimen; however, the specimen confirmed that the resident had an infection and five days later, the Physician ordered an antibiotic to be taken for five days.

After the completion of the antibiotics, the resident continued to exhibit symptoms of confusion, lethargy, decreased appetite and behavioural changes. The clinical record indicated that staff documented two days after the start of the treatment for this infection, 12 days after the start of the treatment and 14 days after the start of the treatment, resident #300 had repeated bouts of emesis and family requested that the home send the resident to hospital due to their condition.

The resident was transferred to hospital, and was hospitalized for five days due to this infection, dehydration and other complications.

It was confirmed by the Director of Care (DOC) during an interview on April 7, 2016, that resident was neglected by staff when the home failed to provide the resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction that jeopardized the health, safety or well-being.

PLEASE NOTE: This area of non-compliance was identified during a complaint inspection, log #020583-15, conducted concurrently during this RQI. (Inspector 508)

(508)

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

Sep 30, 2016(A1)

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

(A1)
The licensee shall prepare, submit and implement a plan to ensure that when bed rails are used the resident and their bed system is evaluated to minimize risk to the resident and where risk has been identified, steps are taken to prevent resident entrapment. The plan is to include but is not limited to the following:
1. Complete an interdisciplinary re-audit of all bed systems by September 2, 2016 to ensure mattresses are secured within mattress keepers and there is not lateral movement of the mattresses on the bed decks.
2. The development and implementation of an interdisciplinary training program for staff who participate in the assessment of the resident when bed rails are used. This training is to be based on directions contained in the guidance document “"Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada). The training is to, at a minimum, include factors to be considered when assessing residents, where and how staff document the rationale for the implementation of bed rails or the decision not to implement bed rails, as well as specific information to be documented when the resident's plan of care is developed or revised related to the use of bed rails.
3. The development and implementation schedule for the interdisciplinary reassessment of all residents who use one or more bed rails based on the above noted training by September 2, 2016.
4. The development and implementation of a bed safety training program for staff who provide care to residents and for staff who are responsible for auditing bed safety. The training program at a minimum shall include information related to the risks associated with the use of bed rails, alternatives to the use of bed rails, when and under what circumstances bed rails will be used in the home, how to recognize when a bed system is unsafe, how and when to report bed safety concerns, and how to apply any entrapment zone interventions if necessary.
5. The development and implementation of a program for monitoring compliance related to the assessment and reassessment of residents for the use of bed rails.

The plan is to be submitted on or before August 8, 2016 to Phyllis Hiltz-Bontje at Phyllis.Hiltzbontje@Ontario.ca.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (3) and compliance history (2), in keeping with s.299 (1) of the Regulation, in respect to the potential for actual harm to a large number of residents and the widespread scope when 72 percent of residents audited were identified as having bed safety concerns.

2. The licensee failed to ensure where bed rails were used, the resident was assessed, his or her bed system was evaluated and steps were taken to prevent resident entrapment, in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Prevailing practices are identified in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), the decision to use, continue to use, or to discontinue the use of a bed rail should be made within the context of an individual resident assessment using an interdisciplinary team with input from the resident or the residents substitute decision maker. The guideline emphasizes the need to document clearly whether interventions were used and if they were appropriate or effective. Other questions to be considered would be the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors and the status of the resident's bed (whether passed or failed zones 1-4). Consideration of these factors could more accurately guide the assessor in making a decision, with either the resident or by the resident's Substitute Decision Maker (SDM) about the necessity and safety of a bed rail. The final conclusion would then be documented on a form (electronically or on paper) as to why one or more bed rails were required, the type of rail, when the rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

3. The licensed failed to assess residents in accordance with prevailing practices when the use of bed rails was included in the resident's plan of care.
a) During the initial course of this inspection, Inspector # 214 observed that resident #007 had two quarter bed rails in the "up" position on their bed. A review of the resident's plan of care indicated that two quarter bed rails were used as personal

assistive services devises (PASD) and that the resident would use the bed rails to assist in positioning while in bed. At the time of this inspection registered staff #029 confirmed that they were unable to provide any documentation to confirm that resident #107 had been assessed prior to the bed rails being added to the resident's plan of care.
b) Observations made on April 19, 2016 of resident #201's bed system confirmed the mattress was not held within the mattress keepers, slid easily from side to side on the bed deck and a three quarter length bed rail was noted in the "up" position on the left side of the bed. Resident #201's plan of care indicated under both a safety and mobility care focus that the resident used one three quarter bed rail for positioning. The Resident Assessment Instrument (RAI) Coordinator confirmed that the assessment tool staff used when an assessment for the use of bed rails was required was titled "Safety Assessment – falls, restraints and bed rails" and that this tool was also used when a reassessment of the resident's need for the use of bed rails was completed. The above noted "tool" completed for resident # 201 on February 11, 2016 confirmed that registered staff selected data points that indicated the bed rail was at the request of the resident/family, a "Living at Risk" form had been signed and the bed rail was used for personal care, but did not identify how or why this resident used the bed rail during personal care. Registered staff #029 and the clinical record confirmed that there was no documentation on the assessment form, in progress notes or in any other part of the clinical record that assessed the resident's need/ability to use the three quarter bed rail on the left side of the bed for personal care or what alternatives to the use of one bed rail were considered at the time of the assessment.
A reassessment of the use of one three quarter bed rail on the left side of the bed for resident #201 was completed using the above mentioned assessment tool on April 26, 2016. The registered staff completing this assessment selected the same data points as were selected on the February 11, 2016 assessment. A review of the clinical record confirmed that there was no documentation on the assessment tool, in progress notes or in any other part of the clinical record that demonstrated the resident was observed for the use of the bed rail, that there was an ongoing need for the use of the bed rail or if alternatives to the use of the bed rails were considered at the time of the reassessment.
c) Observations made on April 21, 2016 of resident #202's bed system confirmed that the mattress was not held within the mattress keepers, the mattress slid easily from side to side on the bed deck and one three quarter bed rail was noted in the "up position on the left side of the bed. Resident #202's plan of care indicated under both a safety and mobility care focus that the resident used one three quarter bed rail to

assist with bed mobility. The resident's initial "Safety Assessment- falls, restraints and bed rail" tool completed on May 13, 2015 indicated that the resident had requested the bed rail, the resident had signed a "Living with Risk" form, bed rails were not needed during personal care and the resident had a three quarter bed rail at night to help with repositioning. Data collected and documented in the clinical record indicated resident #202's physical functioning, specifically related to bed mobility deteriorated from requiring supervision with one person physical assist on June 8, 2015, to requiring extensive assistance with one person physical assist on August 7, 2015 and then to requiring extensive assistance with two (plus) person physical assist on November 7, 2015. Documentation indicated that the resident continued to require extensive assistance with two (plus) person physical assist from January 30, 2016 up to and including the time of this inspection. A bed rail reassessment completed for resident #202 on August 15, 2015 and February 18, 2016 were not based on an individual resident assessment when there was no indication of the impact of the resident's deteriorating condition related to bed mobility and this factor was not considered in determining the ongoing need for the use of bed rails for this resident.

4. The licensee failed to assess resident's bed systems in accordance with prevailing practices when the uses of bed rails were included in the resident's plan of care.
During the initial phase of this inspection it was observed by both Inspector # 514 and Inspector # 129 that several resident bed systems were observed to not have the mattresses contained within the mattress keepers and those mattresses slid from side to side easily on the bed deck.
The Environmental Supervisor (ES) confirmed that they had completed a bed entrapment audit on March 10, 2016, that they were trained to complete this audit by an identified bed/mattress manufacturer and that the home had and used the appropriate equipment while completing this audit. The record of this audit indicated that all bed systems in the home passed entrapment zones except one and there was no indication on this record that there was an issue with the mattresses not being contained within the mattress keepers or that mattresses were noted to slide easily from side to side on the bed decks. A review of resident's bed systems was completed with the ES on April 21, 2016. The ES confirmed following this review that of the 32 occupied beds systems reviewed, 23 of those beds failed to meet bed system safety requirements and these bed systems failed because the mattresses were not contained within the mattress keepers and all of these identified mattresses were noted to slide easily from side to side on the bed decks. It was also noted

during this review that all 23 bed that failed were noted to have one or more bed rails in the "up" position. During the course of the review PSW staff #033 and #062 entered one of the rooms while this Inspector and the ES were reviewing the bed systems and PSW staff #033 indicated that the fitted sheets being used in the home were so tight that they pulled the mattresses up out of the mattress keepers and at the time of this review the ES considered this situation as a possible cause of the mattresses not resting in the mattress keepers and creating potential entrapment risks.

5. The licensee failed to ensure that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [15(1)(b)] While reviewing the "Bed/Entrapment Audit Report" completed by the ES on March 10, 2016, it was confirmed that one bed system had failed to prevent possible resident entrapment. The ES confirmed that this bed system had failed because the mattress was an air surface. Observations of this bed system made with the ES and the Maintenance Lead confirmed that there was an air mattress on the bed and one three quarter bed rail was noted in the "up" position on right side of the bed. The ES indicated the resident had signed a "Living at Risk" form and that no action had been taken to mitigate the risk of potential entrapment for this resident. [s. 15. (1)]

(129)

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

Sep 30, 2016(A1)

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the written plan of care:
a) Sets out the planned care for all residents, including resident #404, related to resident transfers, any transfer and positioning devices used specific transfer techniques as well as the number of staff required for safe resident transfers.
b) Sets out clear directions to staff and others who provide direct care to all residents, including resident #100 related to oral care and resident #109 related to the application of restraining devices.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (1) and compliance history (4), in keeping with s.299 (1) of the Regulation, in respect to the potential for actual harm to resident #109, the scope of "isolated" within the context of a Resident Quality Inspection and the licensee's history of non-compliance (VPC) May 6, 2014 Resident Quality Inspection with the s. 6(1)(c) related to written plan of care providing clear directions to staff and others who provide direct care to residents.

2. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident. [6 (1) (a)])

a) A review of a Critical Incident System (CIS) report that was completed by the home indicated that on an identified date, while staff were assisting resident #404 to transfer from their bed to their chair was using a mechanical lift, they became weak resulting in a fall onto the floor. The resident sustained two injuries as a result.

A review of the resident's written plan of care in place for 60 days prior to the incident, indicated that there was no plan or interventions in place regarding the residents needs and preference for how the resident was to be transferred; any transferring and positioning devices or techniques to be used and how many staff were required during transfer of the resident.
An interview with the DOC and the RAI Coordinator confirmed that there was no plan in place regarding the resident's needs for transferring and lifting at the time of this incident when the resident sustained an injury as a result of a fall from a transferring device.

3. The licensee failed to ensure that the written plan of care set out clear directions for staff who provide care to the resident. [6 (1) (c)]

a) Resident #109's written plan of care did not provide clear in relation to a care focus to address an identified visual impairment. The resident was identified as having a visual impairment with decreased visual acuity related to aging for which they no longer used corrective lenses. The DOC, PSW staff #047, PSW staff #049 and the written plan of care confirmed that care interventions did not provide clear directions to staff who provided care when the plan directed staff to "adapt the environment to the resident's individual needs to ensure they are able to recognize their own environment". The above noted staff confirmed that the written plan of care did not provide specific information related to the needs of the resident or how the environment was to be adapted. (Inspector #129)

b) The written plan of care for resident #109 did not provide clear direction for staff, in relation to the application of a restraining device. The resident's written plan of care directed staff "to ensure the restraining device was securely snug to fit the resident". PSW staff # 070 confirmed that the vendor who affixed the restraining device indicated that staff were to apply the device in a very specific way to ensure it was correctly applied for this resident. This direction for the application of the restraining device was confirmed by a diagram included in the home's restraint policy. The resident's plan of care did not provide this specific direction to staff providing care and on March 31, 2016 it was observed and confirmed by registered staff # 011 and PSW staff #070 that the restraining device had not been applied according to the specific directions and had been applied in an unsafe manner with a 14 inch gap between the resident's body and the restraining device. (Inspector # 129)
(214)

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

Sep 30, 2016(A1)

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Order / Ordre :

The licensee shall ensure that the written plan of care is based on an assessment of all resident's needs and preferences, including resident #100 related to oral care needs, resident #102 related to urinary continence and care, resident #108 related to bowel continence and care as well as resident #404 related to care needs upon return from hospital.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (1) and compliance history (4), in keeping with s.299 (1) of the Regulation, in respect to the risk of minimal harm or potential for actual harm to resident #100, resident #102, resident #108 and resident #404, the scope of "isolated" within the context of a Resident Quality Inspection and the licensee's history of non-compliance (VPC)

May 6, 2014, Resident Quality Inspection with the s. 6(2) related to the care set out in the plan of care based on an assessment of the resident and the needs and preferences of that resident.

2. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

a) A bladder and bowel assessment had been completed for resident #108 in January and in March, 2016. A review of these assessments indicated that the resident was frequently incontinent of urine and occasionally incontinent of bowel. The resident's plan of care for this time period identified that the resident was frequently incontinent of urine. The plan also identified that the resident was on a toileting program to assist the resident in managing their urinary incontinence.
The plan of care did not contain any of the information related to the resident's level of bowel continence as identified in the bowel and bladder assessments.
It was confirmed by the RAI Coordinator during an interview on April 18, 2016, that the care set out in the resident's plan of care was not based on an assessment of the needs and preferences of that resident. (Inspector # 508)

b) The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.
A review of resident #100's Oral Health Assessment dated October 11, 2015, indicated that barriers to oral care or dental treatment for the resident were that the resident refused oral hygiene and would not open their mouth. The assessment indicated that the resident used a sponge swab and oral rinse for their oral care need supplies. The assessment indicated under details and interventions for oral health and hygiene that one staff was to set up the resident at the sink with a glass and oral rinse and that staff were to observe and cue the resident while they rinse their mouth with mouth wash. Staff was to also use a sponge swab to clean the resident's mouth as they will turn away when a toothbrush was used.
A review of the resident's written plan of care for oral care and dated October 21, 2015, indicated that one staff was to set up the resident at the sink and cue the resident to rinse their mouth in the morning and at bedtime; however, the plan had not indicated that the resident may refuse oral hygiene or may not open their mouth and also had not indicated that staff were to use a sponge swab to clean the resident's mouth as they may turn away when a toothbrush is used.
An interview with the DOC and the RAI Coordinator confirmed that the care set out in the plan of care was not based on the assessed needs and preferences of the

resident. (Inspector #214)

c) A review of resident #102's quarterly minimum data set (MDS) coding dated December 12, 2015, indicated under section H. - Continence in the last 14 days that the resident was coded as being frequently incontinent of their bladder and that their urinary continence had not changed as compared to their status 90 days ago. A review of the corresponding narrative Urinary Continence Resident Assessment Protocol (RAP) also indicated that the resident was frequently incontinent of their bladder.
A review of the resident's written plan of care dated December 17, 2015, indicated under the focus for toileting and urinary incontinence, that the resident was occasionally incontinent of their bladder.
An interview with the RAI Coordinator on April 14, 2016, confirmed that the care set out in the plan of care had not been based on an assessment of the resident and their needs. (Inspector #214)

d) A review of a Critical Incident Submission (CIS) that was completed by the home indicated that on an identified date, while staff were assisting resident #404 to transfer from their bed to their chair using a mechanic lift, they became weak resulting in a fall onto the floor. The resident sustained two injuries as a result.
A review of the resident's written plan of care for the time period of August 29 – October 8, 2015, indicated under the transfer focus that the resident was to be transferred via total mechanical lift with 2 persons in attendance. The created date of this intervention was August 30, 2015. According to the resident's clinical records, the resident was not in the home at the time this intervention had been added to the plan of care.
An interview with the DOC and RAI Coordinator confirmed that the resident was not in the home at the time this intervention was added to the plan of care and that the plan of care had not been based on the assessed needs and preferences of the resident.

(214)

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

Sep 30, 2016(A1)

Order # / Ordre no : 005 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, 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 :

The licensee shall ensure that:
a) All care staff are made aware of the locations within the plan of care where care may be set out for the resident.
b) Registered staff review the plans of care, as necessary, to ensure that the directions for care are clearly set out in the document(s) the home uses to direct the care of the resident.
c) Registered staff monitors the care being provided to ensure that specific care directions are being followed for all residents, including resident #300 related to the collection of specimens, resident #101 related to special nutritional interventions and resident #107 related to fall prevention strategies.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (5), in keeping with s.299 (1) of the Regulation, in respect to the actual harm resident #300 experienced and the potential for actual harm to resident #101 and resident #107, the scope of "isolated" within the context of a Resident Quality Inspection and the licensee's history of multiple non-compliance

(VPC) May 6, 2014 Resident Quality Inspection and (VPC) April 14, 2015 Complaint Inspection with s. 6(7), related to care not being provided as specified in the plan of care.

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

a) A review of resident #101's current written plan of care indicated under nutrition that staff was to provide the resident with a choice of specifically modified fluids at identified intervals daily; provide 125 millilitres of a specifically modified fortified drink at identified intervals and that staff were to provide a specific diet with specifically modified fluids and a number of foods were identified to be provided to the resident. A review of resident's food and fluid records from April 1-11, 2016, indicated that several entries under the food column for meals and snacks were blank or had a zero (0) amount entered. An interview with PSW #030 indicated that the resident was not provided with the specific diet items identified in the plan of care and that this had been clarified with registered staff #009 approximately one week prior. An interview with the FSNM confirmed that the resident was assessed and that the plan of care from April 1-11, 2016 was accurate based on the assessment of the resident's needs. The Food Service and Nutrition Manager (FSNM) indicated that dietary staff served the meals and nursing staff provided the assistance for eating. An interview with dietary staff #088 on April 12, 2016, confirmed that the resident was only provided with a specifically modified fluid and a modified fortified drink for their breakfast meal on this day.
A review of the resident's snack menu indicated that specific directions related to food were documented in bold letters and in small letters staff were directed about other foods to provide to the resident. An interview with the FSNM indicated that labelled snacks would be implemented and the FSNM confirmed that the care set out in the residents plan had not been provided to the resident as specified in their plan. On April 13, 2016, a memo was observed to be posted at the nursing station with a date of April 12, 2016. The memo was titled, "Daily meal/snack pattern" and contained a detailed menu of the items that resident #101 was to receive for each snack and meal time as identified in their written plan of care. (Inspector #214)

b) Resident #107 was not provided with care as set out in their plan of care. The resident's plan of care identified a care focus related to restraint/safety and directed staff to ensure the resident's bed was in the lowest position at all times when in bed. Staff #042 and observations made at 1515hrs on April 18, 2016 confirmed that the

resident's bed was not placed in the lowest position when the resident was noted to be in bed. (Inspector # 129)

c) Resident #300 had history of infections, and on an identified date, the resident's Substitute Decision Maker (SDM) had requested that staff obtain a specific laboratory specimen due to a change in the resident's condition.
Ten days later, the SDM again requested that the specific laboratory specimen be obtained for resident #300 as it had not been obtained after the initial request.
A review of the resident's clinical health record indicated that the Physician had signed the home's medical directive which included an order to obtain this specific laboratory specimen, using a specific method under an identified situation for residents.
Resident #300 demonstrated the identified situation described in the above noted medical directives signed by the Physician. The identified specimen was not obtained until 42 days after the SDM had originally requested the laboratory specimen be obtained and while obtaining the specimen staff had not followed the specific directions contained in the medical directives for obtaining the specimen and the specimen was contaminated.
This specimen confirmed that the resident had an infection and four days later the Physician ordered an antibiotic to be taken for five days.
After the completion of the antibiotics, the resident continued to exhibit symptoms of confusion, lethargy, decreased appetite and behavioural changes and on an identified date, family requested that the home send the resident to hospital due to their condition.
The resident was transferred to hospital and was hospitalized for five days due to this infection, dehydration and other complications.
It was confirmed by the DOC during an interview on April 7, 2016, that care set out in the plan of care was not provided to resident #300 as specified in the plan of care.

(214)

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

Sep 30, 2016(A1)

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all resident's, including resident #108, resident #305, resident #303, resident #106, resident #107, resident #104, resident #109, resident #102 and resident #404 are reassessed and their plan of care are reviewed and revised at least every six months and whenever their care needs change.
The plan is to include, but not limited to the following:
1. The development and implementation of a schedule for an interdisciplinary review of the above noted resident's plans of care to ensure they are based on the resident's current care needs.
2. The development and implementation of appropriate education that includes; the roles, responsibilities and scheduled intervals for interdisciplinary reassessment of residents, what constitutes a change in a resident's care needs, what action staff are to take when a change in care needs has been identified and where the action taken in response to the change in care needs is to be documented in the resident's plan of care..
3. The development and implementation of system for monitoring compliance with scheduled reassessments, that reassessments are completed whenever it has been identified that a resident's care needs have changed and that action taken to address the change in care needs has been documented in accordance with the training provided above.
The plan is to be submitted on or before August 8, 2016 to Phyllis Hiltz-Bontje at Phyllis.Hiltzbontje@Ontario.ca

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (2) and compliance history (4), in keeping with s.299 (1) of the Regulation, in respect to the minimum risk to resident #102 and the potential for actual harm to resident #404,resident #108, resident #106, resident #104, resident #107, resident #305, resident #303 and resident # 109, the scope of "pattern" within the context of a Resident Quality Inspection and the licensee's history of non-compliance (VPC) April 15, 2015, Complaint Inspection, related to the resident not being reassessed and their plan of care reviewed and revised when the resident's care needs changed.

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

Resident #108, staff and the clinical record confirmed that the resident used a

restraining device as a personal assistive services device (PASD) for positioning control. The RAI Coordinator confirmed that the home used an assessment tool identified as “Safety Assessment-fall, restraint and bed rail” which was located in the assessment tab of the computerized clinical record to assess residents who fall, are being restrained, use bed rails or use a PASD. The RAI Coordinator confirmed that the above noted assessment completed on September 26, 2015, January 10, 2016 and March 31, 2016 did not indicate that the resident used a restraining device for positioning control and there was no indication that the ongoing need for this PASD and any potential risks associated with its use had been reassessed during this six month period of time. (Inspector # 129)

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed. [6(10)(b)]

(i) On an identified date, resident #304 was witnessed by staff to inappropriately touch resident #305.
The staff member intervened, separated the residents and removed resident #305 from the area. A review of resident #305's clinical record indicated that resident #305 had severe cognitive impairment and was not capable of consenting to inappropriate touching.
The Critical Incident report submitted by the home the following day, had indicated that their long term action plan was to ensure that these two residents would not be seated in close proximity of each other to minimize a recurrence.
The resident's plan of care that staff refer to for direction in providing care to residents was not revised with this intervention. There was also no revision in the resident's responsive behaviour plan of care to indicate that resident #304 had the potential for inappropriate touching towards co-residents.
It was confirmed by the DOC during an interview on April 22, 2016, that resident #304's plan of care was not reviewed and revised when the resident's care needs changed.

(ii) A review of the Critical Incident (CI) report submitted by the home on an identified date, indicated that resident #302 inappropriately touched resident #303. Resident #303 did not consent to the touching and staff who witnessed the incident immediately separated the residents and reported the incident to the registered staff. Under the section IV of the CI, titled, Analysis and follow-up, the home indicated that immediate actions taken to prevent a recurrence of the incident was that recreation staff were made aware not to seat the two residents near one another for group

activities and that this would be added to resident #303's plan of care.
A review of resident #303's plan of care indicated that the plan had not been updated with this intervention.
It was confirmed by the Programs Manager during an interview on April 15, 2016, that the plan of care for resident #303 had not been reviewed and revised when the resident's care needs changed.

(iii) A review of the wound care assessments for resident #106 indicated that the resident had developed a wound on an identified body part.
A review of the resident’s plan of care between October 2015, and January 2016, indicated that the resident had a plan of care focus related to skin integrity. The interventions identified that the resident had a wound on another identified body part that was different from the wound identified above.
The plan of care had not been updated when it had been identified that the resident developed a new wound.
It was confirmed during an interview with staff #015, on April 13, 2016, that when the resident was assessed the plan of care was not reviewed and revised when the resident’s care needs changed.(Inspector # 508)

(iv) A review of the Minimum Data Set (MDS), dated November 11, 2015, under section I - Disease Diagnosis, indicated that resident #107 had a diagnosis of a respiratory infection.
Further review of the clinical record indicated that the resident had been diagnosed with respiratory infections in two identified months in 2015 and one identified month in 2016. The resident was treated with antibiotics and staff assessed the resident during the course of the treatments.
A review of the resident's plan of care indicated that the resident's plan had not been reviewed and revised when the resident was diagnosed and treated for these respiratory infections.
It was confirmed by the RAI Coordinator during an interview on April 13, 2016, that the resident's plan of care was not reviewed and revised when the resident's care needs changed. (Inspector # 508)

(v) Resident #104 started exhibiting symptoms of a Upper Respiratory Infection(URI) on an identified date, and was started on antibiotics three days later. The resident’s condition continued to decline until their death 11 days later.
A review of the resident’s clinical record indicated that when the resident’s condition changed, the resident’s plan of care had not been revised.

It was confirmed by the RAI Coordinator on April 12, 2016, that the resident #104's plan of care was not reviewed and revised when the resident's care needs changed. (Inspector # 508)

(vi) Resident #109's plan of care was not reviewed or revised when the resident's care needs changed in relation to the demonstration of responsive behaviours. The resident's plan of care for the management of an identified visual deficit directed staff to place utensils within the resident's line of vision and within reach. During observation on March 29, 2016, it was noted that the resident's utensils were not within reach of the resident. At this time personal support staff indicated that the resident was not provided with any utensils because resident demonstrated responsive behaviours. The DOC, PSW staff # 047 and PSW staff #049 confirmed that the plan of care had not been updated and that the resident was not provided with any utensils due to responsive behaviours the resident demonstrated. (Inspector #129)

(vii) A review of resident #102's written plan of care dated April 5, 2016, indicated under oral care interventions with a revised date of April 9, 2015, that staff were to apply toothpaste to the residents toothbrush and the resident will attempt to brush their teeth. Interventions also included that staff would provide the resident with diluted mouth rinse for them to rinse their mouth.
An interview with PSW # #071 confirmed that a toothbrush and toothpaste were not used as part of the resident's oral care supplies and that only a toothette/swab was used followed by mouthwash and that this has been in place "forever".
An interview with the DOC confirmed that the plan of care was not reviewed and revised when the resident's care needs changed. (Inspector #214)

(viii) A review of a Critical Incident Submission (CIS) that was completed by the home indicated that on an identified date while staff were assisting resident #404 to transfer from their bed to their chair using a mechanical lift, the resident became weak, which resulted in a fall onto the floor. The resident sustained two injuries as a result.
A review of the resident's clinical records indicated that they returned to the home from hospital on an identified date and that a lift and transfer assessment had been completed on this date and the resident was determined to need the use of a total mechanical lift for all transfers.
A review of a Physiotherapy assessment completed in the computerized record indicated that the Physiotherapist (PT) assessed the resident following their return

from hospital. The assessment indicated that the resident was weight bearing as tolerated as per their hospital orders and that during this assessment; the resident complained of pain and as a result was not up to trying to stand for the assessment. An interview with the Physiotherapist confirmed that the resident was unable to stand when conducting their assessment and that the resident's plan of care was not revised for approximately five weeks following the resident's change in their care needs
(129)

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

Sep 30, 2016(A1)

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all resident's, including resident #101, resident #107 and resident #109 are assessed using an interdisciplinary approach and that actions are taken and outcomes evaluated when it has been identified that a weight change in accordance with O. Reg. 79/10, s. 69 has occurred. The plan is to include, but not limited to the following:

1. A schedule for the review of nutritional care policies, procedures and protocols in place in the Dietary and Nursing Department manuals related to the management of weight change. If this review identifies that the role/responsibilities for each member of the interdisciplinary team are conflicting or unclear or if it is identified that the procedures, policies and/or protocols in place do not provide clear direction to staff a schedule for the revision of the policies, procedures or protocols is to be included in this plan.
2. The development and implementation of a training program so that all staff will know their role and responsibilities in the management of weight change to comply with the nutritional care policies and procedures.
3. The development and implementation of a system for monitoring compliance with the policies, procedures and protocols established related to the management of weight change.

The plan is to be submitted on or before August 8, 2016 to Phyllis Hiltz-Bontje at Phyllis.Hiltzbontje@Ontario.ca

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (3) and compliance history (2), in keeping with s.299 (1) of the Regulation, in respect to the potential for actual harm to resident # 101, resident #107 and resident #109 and the widespread scope when three of three resident's audited were affected in related to the management of weight changes.

2. The licensee failed to ensure that residents with a weight change of five percent of body weight or more, over one month; 7.5 percent of body weight or more, over three months and 10 percent of body weight, or more over six months, were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

a) Resident #109’s plan of care indicated the resident was at high nutritional risk. The resident experienced a significant weight change over a one month, three month and six month period of time and this weight change was not assessed. Staff and the clinical record confirmed that following the recording of the resident’s weight on an identified date as 32.4 kilograms, a computer generated flag alerted staff the resident had experienced a 5.3 percent weight loss over one month, an 8.7 percent weight loss over three months and a 12.19 percent weight loss over six months. The Director of Care (DOC), the Resident Assessment Instrument (RAI) Coordinator, the Registered Dietitian (RD) and the clinical record confirmed that nursing staff and dietary staff did not respond to the alert notifying them the resident had experienced a significant weight loss. The above noted staff also confirmed that the resident had not been assessed, and actions were not taken to manage the identified weight loss up to and including the time of this inspection. (Inspector #129)

b) Resident #107’s plan of care indicated the resident was at moderate nutritional risk. The resident experienced a significant weight loss of 6.4% over a one month period of time in the fall of 2015. A Resident Assessment Protocol (RAP) completed at that time confirmed the resident had experienced a significant weight loss over one month, however; no actions were taken to manage this weight loss. Resident #107 continued to experience weight loss and the following month the clinical record confirmed that the resident had experienced an 8.6 percent weight loss over a three month period of time. The RD and clinical documentation confirmed that this weight change was not assessed and actions were not taken to manage this ongoing weight loss. (Inspector #129)

c) A review of resident #101’s documented weights in the clinical record indicated that over a one month period of time in the winter of 2016 the resident experienced a weight loss of 5.8 per cent. The following month the clinical record indicated the resident had experienced an 8.4 per cent weight loss over a three month period of time and the following month the clinical record indicated the resident had experienced a 17.6 per cent weight loss over a six month period of time. The clinical record indicated that no assessments had been completed when the resident was identified as having experienced a 5.8 percent weight loss over one month, an 8.5 percent weight loss over three months or a 17.6 percent weight loss over six months. An interview with the RD confirmed that the resident was not assessed when they demonstrated the weight changes noted above. (Inspector #214)

(129)

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

Sep 30, 2016

Order # /
Ordre no : 008

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that any plan, policy protocol, procedure, strategy or system is complied with. The plan is to include, but not limited to the following:

1. The development and implementation of a schedule for the review of the following policies and/or procedures to ensure staff roles and responsibilities are clear and the directions contained in the policies and/or procedures provide clear direction to staff: "Weight Review" procedure identified as CD-05-28-1, dated June 2010, the "Weight Scale and Weighing Residents" procedure, identified as CN-W-02-1, dated August 2010, the "Restraints" policy, identified as CN-R-05-1, dated December 2015, the "Bed Rail-Safe Use and Entrapment Risk Management" policy identified as CN-B-08-1 and dated September 2014, the "Pain Management" policy, identified as CN-P-09-1 and dated January, 2016, the "Skin Care and Wound Care" policy, identified as CN-S-13-3 and dated November 2015, the "Height" procedure, identified as CN-H-09-1 and dated March 2011 and the "Safe Resident Handling Policy", identified as CHS-1-20-1 with a revision date of March 2016.

2. The development and implementation of appropriate education for all of the policies and/or procedures identified in this order.

3. The development and implementation of a system for monitoring compliance with the policies and/or procedures in this order.

The plan is to be submitted on or before August 8, 2016 to Phyllis Hiltz-Bontje at Phyllis.Hiltzbontje@Ontario.ca

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (3) and compliance history (4), in keeping with s.299 (1) of the Regulation, in respect to the risk of the potential for actual harm, the scope of "widespread" within the context of a Resident Quality Inspection and the licensee's history of non-compliance (VPC) June 24, 2015, Resident Quality Inspection with the r. 8(1)(b) related to ensuring that any plan, policy protocol, procedure, strategy or system was complied with.

2. The licensee failed to ensure that staff complied with the home's policy "Pain Management", identified as #CN-P-09-1 and dated January 2016.
Resident #302 had a fall which resulted in an injury on an identified date. The resident was treated in hospital and returned to the home.
A review of the home's policy #CN-P-09-1, Pain Management, dated January, 2016, under the procedures to manage residents for pain, indicated that the interdisciplinary team will assess residents for pain upon re-admission, quarterly or change in condition that impacts pain or causes new pain or if the resident indicates ongoing unrelieved pain.
A review of the resident's clinical health record indicated that the resident was not reassessed upon the re-admission. Records indicated that the resident's pain assessment had not been conducted until 12 days after the resident was re-admitted.

It was confirmed by the Director of Care during an interview on April 8, 2016, that the home's Pain Management policy was not complied with. (Inspector # 508)

3. The licensee failed to ensure that staff complied with the home's policy "Skin Care and Wound Care", identified as #CN-S-13-3 and dated November 2015.
Resident #105 had a fall on an identified date that resulted in an injury. The resident received treatment in hospital and returned to the home.
A review of the home's Skin Care and Wound Care policy #CN-S-13-3, dated November, 2015, under the skin assessment section, directed staff to complete a skin assessment upon admission, quarterly, upon return from hospital and upon return from leave of absence (LOA) greater than 24 hours using the Skin and Risk Assessment Tool.
A review of the resident's clinical record indicated that staff did not complete this assessment when the resident returned from the hospital.
It was confirmed by the Resident Assessment Instrument (RAI) Coordinator during an interview on April 7, 2016, that staff had not complied with the Skin and Wound Care policy. (Inspector # 508)

4. The licensee failed to ensure that staff complied with the home's protocol to assess a resident who has fallen for injury prior to moving them. This protocol was identified by the Director of Care (DOC).
Resident #105 experienced an unwitnessed fall on an identified date. This incident was reported to the Registered Nurse (RN) by a PSW who found the resident. A review of the resident's clinical record indicated that the resident complained of extreme pain and was demonstrating a behaviour that would suggest pain was being

experienced.
Three staff members lifted the resident from the floor and put the resident into bed to do an assessment. The resident was assessed and transferred to hospital where it was confirmed that the resident had sustained an injury.
During an interview with the DOC, the DOC had indicated that the home’s protocol of when a resident is found on the floor, was that the resident is not moved until an assessment had been conducted.
It was confirmed by the DOC during an interview on April 13, 2016, that the protocol to assess residents when residents are found on the floor post fall was not complied with. (Inspector # 508)

5. The licensee failed to ensure that staff complied with the home’s policy “Weight Change Policy” identified as #CN-W-04-1 and dated August 2010.
This policy directed that, every resident will be weighed monthly and the weight will be recorded in the weight book. Any resident with a significant weight change of 5% in one month, 7.5% over 3 months, 10% over 6 months will be reweighed by nursing staff as soon as possible after the noted weight change is recorded. If there is a significant weight change or if there is any other weight change that compromises the resident’s health status the FSNM and Registered Dietitian will be notified to intervene. The Registered Dietitian will chart what actions will be taken, update the care plan and evaluate the outcomes.

a) Clinical documentation confirmed that resident #101 experienced a 5.8 percent weight loss over a one month period of time in the winter of 2016, an 8.4 percent weight loss over a three month period of time the following month and a 17.6 percent weight loss over a six month period of time. An interview with registered staff #011 indicated that nursing staff documented resident’s weight on a paper form titled, “Weights for Residents”. These weights were then entered in the computerized clinical record system and any resident’s requiring re-weights would have their names listed on a sheet of paper that was kept at the nursing station. Staff #011 indicated that the re-weights were not entered into the resident’s clinical record and that the sheet containing re-weights was not given to the RD. A review of the resident’s clinical record including the weight tab in computerized record indicated that no re-weights for the time periods above when the resident demonstrated a significant weight loss, could be located. An interview with the DOC confirmed that the only re-weight that was able to be located for resident #101 was not completed following the above mentioned weight loss. An interview with the DOC confirmed that the home’s policy with regards to weight change had not been complied with.

Registered staff #011 indicated that referrals to the RD were completed via a paper referral or an electronic referral in the computerized clinical record. A review of resident #101's clinical record indicated that no paper or electronic referrals to the RD could be located to address the significant weight loss the resident had experienced. An interview with the FSNM confirmed that no referrals with regards to the resident's significant weight loss could be located when it was identified that the resident experienced a 5.8 percent weight loss over a one month period of time, an 8.4 percent weight loss over a three month period of time and a 17.6 percent weight loss over a six month period of time. An interview with the DOC confirmed that the home's policy with regards to weight change had not been complied with. (Inspector #214)

b) Clinical documentation confirmed that resident #109 experienced a 5.3 percent weight loss over one month in the winter of 2016. The DOC, FSNM and the clinical record confirmed that nursing staff did not re-weigh resident #109 when it was identified on March 13, 2016 that the resident has experienced a significant weight loss of 5.3 percent over a one month period of time.
The DOC, FSNM, RD and the clinical record confirmed that when it was identified that resident #109 had experienced a significant weight loss of 5.3 percent over a one month period of time the FSNM and the RD were not notified of this significant weight change, no actions were taken to address this significant weight change and staff in the home had not complied with the policy. (Inspector #129)

c) The DOC, FSNM, RD and the clinical record confirmed that when it was identified that resident #107 had experienced an 8.6 percent weight loss over a three month period, this significant weight change was not assessed and actions were not taken to manage the resident's weight loss. (Inspector #129)

6. The licensee failed to ensure that staff complied with the home's policy "Safe Resident Handling Policy", identified as #CHS-1-20-1 with a revision date of March 2016.
A review of a Critical Incident Submission (CIS) that was completed by the home indicated that on an identified date indicated that while resident #404 was being assisted by staff to transfer from their bed to their chair using a mechanical lift they became weak, fell and sustained an injury.
The CIS indicated that the resident had a lift and transfer assessment completed 12 days prior to this incident. A review of the resident's assessments in the computerized record indicated that a Lift and Transfer assessment had been

completed in the winter of 2015 and not again until after the resident returned from hospital following the above noted incident. The lift and transfer assessment that was identified in the CIS was titled, “Re-admission-V1” and dated August 17, 2015, and completed following the resident’s return from a hospitalization related to a medical condition. A review of this assessment indicated under transfer device that a check mark had been placed beside both a total mechanical lift and another lift and had not included any other information as to how the assessor determined the use of these lifts.
A review of the home’s policy, titled, “Safe Resident Handling Policy” (CHS-1-20-1 with a revision date of March 2016), indicated the following:
i) that all staff conduct a mobility review using the C.A.R.E. module tool on all residents prior to initiating any lift or transfer.
ii) the assessment for lifts and transfers will be reviewed and updated a minimum of quarterly and as required.
iii) Mede-care specific requirement.
An interview with the DOC and RAI Coordinator confirmed that they were not aware of the C.A.R.E. module tool that is to be used on all residents prior to initiating any lift or transfer and confirmed that the home no longer used the requirements identified in the policy because they had changed their computerized record system The DOC and RAI Coordinator confirmed that a lift and transfer assessment had not been completed quarterly or upon the resident’s return from hospital and that the home had not complied with their policy. (Inspector # 214)

7. The licensee failed to ensure that staff complied with the home’s policy ““Height”, identified as #CN-H-09-1 and dated March 28, 2011.
A review of the home’s policy titled, “Height” (CN-H-09-1 and dated March 28 2011) indicated the following:
i) Every resident admitted into facility must have their height recorded within 24 hours of admission.
The Ontario Regulation 79/10, [r.68 (2) (ii)], indicates that the licensee shall ensure that the nutrition care and hydration programs include body mass index and height upon admission and annually thereafter.
An interview with the DOC on April 14, 2016, confirmed that this was the only policy the home had with regards to height and that this policy had not been in compliance with all applicable requirements under the Act. (Inspector #214)

8. The licensee failed to ensure that staff complied with the home’s “Weight Review” procedure identified as CD-05-28-1, dated June 2010 and located in the Dietary

Manual. This procedure directed that the "resident's weight is documented on the identified form; staff completing this document were to determine if the weight loss or gain documented was significant according to the formula included in the procedure, if the weight change was identified as significant staff were to complete a Nutritional Referral and forward it to the Registered Dietitian (RD)". Staff did not comply with this direction when:
Clinical documentation indicated that following the recording of the resident #109's weight on an identified date as 32.4 kilograms, a computer generated flag alerted staff the resident had experienced a 5.3 percent weight loss over one month, an 8.7 percent weight loss over three months and a 12.19 percent weight loss over six months. The Director of Care (DOC), the Food Services and Nutrition Manager (FSNM) as well as the RD confirmed that staff did not use the Weight Review form included in the above noted policy and a referral to the RD was not completed when it was identified in the computerized clinical record that resident #109 had experienced the above noted significant changes in their weight. (Inspector #129)

9. The licensee did not ensure that staff complied with the home's "Weight Scale and Weighing Residents" procedure, identified as CN-W-02-1, dated August 2010 and located in the Nursing Manual.

a) This procedure directed that "registered staff were to review resident's weights for significant discrepancies and if a discrepancy was noted then registered staff were to re-weigh the resident". The DOC, FSNM, Resident Assessment Instrument (RAI) Coordinator and the clinical record confirmed that staff did not comply with this direction when registered staff entered a weight for resident # 109 in the computerized record on an identified date but did not obtain a re-weight for this resident even though when the weight was entered a flag was generated indicating the resident had lost 1.8 kilograms which represented a 5.3 percent weight loss since the weight identified the month previous. (Inspector #129)

b) This procedure directed that "should the resident's weight fluctuate to a significant degree, registered staff were to notify the FSNM and follow the weight change policy". The DOC, FSNM and the clinical record confirmed that the staff did not comply with this direction when the FSNM was not notified that resident #109 had lost 5.3 percent of their weight over one month which was identified as a significant weight loss. (Inspector #129)

10. The licensee failed to ensure that staff complied with the home's "Dietitian

Consultation" procedure, identified as CN-D-06-1, dated April 2011 and located in the Nursing Manual. This policy directed that "in order to determine the cause and to rectify an unexplained weight change of five percent or more of body weight over one month, 7.5 percent or more over 3 months or 10 percent or more in 6 months – nursing will notify FSNM of the need for Dietitian consult and FSNM will notify the Dietitian directly". The FSNM and the RD confirmed staff did not follow this direction when nursing staff did not notify the FSNM that resident #109 was identified as having experienced a 5.3 percent weight change over a one month period of time. (Inspector #129)

11. The licensee failed to ensure that staff complied with the home's "Restraints" policy, identified as CN-R-05-1, dated December 2015 and located in the Nursing Manual. This policy directed that "staff apply the physical device in accordance with any manufacturer's instructions". Registered staff #009 and Personal Support Worker (PSW) # 070 confirmed on March 31, 2016, when it was identified that resident #109 had a restraining device applied that the device had not applied correctly. On the above noted date it was observed that the restraining device had been engaged and there was a 14 inch gap between the device and resident #109's body. At the time of this observation staff in attendance confirmed that they were aware that the restraining device had not been applied according to manufactures directions. (Inspector #129)

12. The licensee failed to ensure that staff complied with the home's procedure for cleaning and disinfecting the whirlpool lift chair. The home posted a procedure on the wall beside the whirlpool that directed staff to "spray and scrub all surfaces which have been lowered into water - make sure you wash all undersides as well". Staff did not comply with this direction when during a tour of the home on March 29, 2016 it was observed and confirmed by the RAI Coordinator that the underside of the whirlpool lift chair was heavily soiled with a white substance. (Inspector #129)

13. The licensee failed to ensure that staff complied with the home's policy "Bed Rail-Safe Use and Entrapment Risk Management" identified as CN-B-08-1 and dated September 2014. This policy directed that "Low air loss surfaces are exempt from the Health Canada Guidelines but risks for entrapment exist and need to be mitigated. Potential solutions include: bolsters and pillows to support the resident, pool noodles between the mattress and the rails, bed rail pads and mattress solution strategies". Staff did not comply with this direction when it was confirmed by the Environmental Supervisor that following the completion of a "Bed/Entrapment Audit" on March 10,

2016 the report indicated that bed an identified bed system had failed entrapment testing because the mattress on the bed frame was a low air loss mattress and that no actions were taken mitigate the risk of entrapment for the resident using this bed system. (Inspector #129)

(129)

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

Oct 31, 2016(A1)

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
Toronto ON M5S 2B1
Télécopieur : 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
Toronto ON M5S 2B1
Télécopieur : 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 26 day of August 2016 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE - (A1)

Service Area Office / Bureau régional de services : Hamilton