Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 13, 2015	2015_267528_0010	H-001829-15	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

BRIERWOOD GARDENS
425 PARK ROAD NORTH BRANTFORD ON N3R 7G5

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

CYNTHIA DITOMASSO (528), LEAH CURLE (585), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 16-20, 23-27, 2015

This inspection was completed concurrently with Complaint inspection log#'s: H-001053-14, H-001057-14, H-001163-14, H-001774-14; Critical Incident System inspection log #'s: H-000798-14, H-001637-14, H-001040-14, H-001747-14, H-001563-14; and Follow-Up inspection log #'s: H-001013-14, H-001014-14, H-001017-14, H-001813-15, H-001814-15 ; H-001016-14 JM 14/05/15

During the course of the inspection, the inspector(s) spoke with the Executive Director, Assistance Executive Director, Director of Care (DOC), Director of Recreation, Volunteers and Spiritual Care, Director of Nutrition Services, Administration Assistant, Resident Services Coordinator/Staff Educator, Resident Assessment Protocol (RAI) Coordinator, Director of Social Services, Environmental Service Manager (ESM), the Corporate Consultant, Registered Dietician (RD), the Cook, Physiotherapist (PT), registered nurses (RNs), registered practical nurses (RPNs), personal support workers, restorative care aide, dietary aides, housekeeping staff, residents and families.

The inspectors also toured the home, observed the provision of care and services, reviewed documents including but not limited to: menus, production sheets, staffing schedules, policies and procedures, meeting minutes, clinical health records, and log reports.

The following Inspection Protocols were used during this inspection:

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

During the course of this inspection, Non-Compliances were issued.
20 WN(s)
10 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 50. (2)	CO #006	2014_240506_0016	528
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #002	2014_240506_0016	585

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 the plan, policy, protocol, procedure, strategy or system was complied with.

A. The home's policy "Transfers, LTC-B-70", last revised August 2012, directed staff to communicate reasons for hospital transfers and details to the resident/substitute decision maker (SDM)/family.

i. In September 2014, the substitute decision maker (SDM) for resident #18 called emergency services from outside of the home and an ambulance was sent to the home to check on the resident. The resident was subsequently transferred to the hospital for assessment. Review of the plan of care did not include any documentation that the home notified the SDM of the transfer until the following day when the SDM called the home to enquire about the resident's status. Interview with registered staff confirmed that the SDM was not notified at the time of the resident's transfer to hospital and any details, as outlined in the policy.

B. The home's policy, "PASD/Assistive Devices, Policy LTC-J-30", last revised August 2012, stated that consent for a Personal Assistance Services Device (PASD)/Assistive Device will be obtained and documented in interdisciplinary progress notes and documentation will be completed every shift on the use of the PASD/Assistive Device.

i. The plan of care for resident #14 identified that the resident required a tilt chair for comfort and positioning. Review of documentation did not include any consent from the SDM. Interview with the Restorative Care Aide confirmed that consent was obtained by the resident's SDM, however, was not documented in the interdisciplinary progress notes.

ii. Further review of resident #14's plan of care on March 19, 2015, did not include documentation on the use of the PASD, which was confirmed by registered staff. (585)

C. The Home's program "Pain Assessment and Symptom Management, LTC-E-80", last revised August 2012, directed the Nurse to review MDS assessment related to pain (sections J2 and J3), and review the Resident's outcomes, RAPs will be completed to determine the need for additional pain assessment and monitoring and/or additional referral.
The policy further identified that:
1. "If the resident complains of pain, a quick pain assessment on the resident will be completed using PQRST and documented";
2. "The resident's pain will be measured using a standardized, evidenced-informed clinical tool",
3. that staff will initiate a pain monitoring tool when "PRN medication is used for 3 consecutive days", and
4. that staff will initiated a pain monitoring tool when "a new regular pain medication is ordered".

i. Resident #16 had an area of altered skin integrity in December 2014, which resulted in pain and as needed (PRN) analgesic use. The clinical record did not include a completed pain assessment with the reports of new pain, the altered skin integrity, which was confirmed by registered staff during a record review. A review of the Medication Administration Records (MAR) and progress notes identified that the resident consecutively used as needed analgesic for three days in December 2014, and January 2015,. The clinical record did not include any pain monitoring tools completed for the identified periods of time, as confirmed by registered staff during a record review. Registered staff confirmed the program expectations for the completion of a pain assessment and pain monitoring tools; however, confirmed that these would be maintained in the resident's record, if completed and could not be located. (168)

ii. Resident #19 voiced concern of pain in the lower extremities in February 2015. This pain was communicated to the physician who ordered an analgesic to be administered routinely at bedtime. A review of the clinical record did not show that a pain monitoring tool had been initiated when the new regular pain medication was ordered, as confirmed during a record review by the DOC. The program was not complied with. (168)
iii. The plan of care for resident #18 identified that the resident was receiving regular pain medication for pain related to arthritis. In September 2014, the resident had an increase in pain resulting in a change in the frequency of regular scheduled pain medication.

Review of the plan of care did not include a pain monitoring tool after a change in regularly scheduled pain medication. Interview with two registered staff confirmed that the resident's responses and effectiveness of the change in pain medication was not monitored and documented using the pain monitoring tool, as outlined in the policy. (528)
iv. The plan of care for resident #10 identified that the resident had moderate pain less than daily and was receiving a non-steroidal anti-inflammatory regularly. An increase in responsive behaviours was noted in June 2014 and additional pain medication was ordered, to be administered on an as needed basis. In August 2014, the regular anti-inflammatory pain medication was changed to a long acting controlled substance. A care conference held in August 2014, identified that pain may be a contributing factor to the increase in the resident's behavours. Review of the plan of care did not include any pain monitoring tool after pain medications were changed in June or August 2014. During an interview with registered staff on March 19, 2015, it was confirmed that the pain monitoring tool should be completed following a change in pain medications to evaluate the effectiveness of the drugs. Interview with the DOC, confirmed the pain monitoring tool was not completed for resident #10 following changes in pain medications in June and August 2014, as outlined in the policy.(528)

D. The home's Policy for "Continence Care, LTC-E-50", last revised May 2013, directed staff to initiate a three day continence assessment on admission and or if there is a change in level of continence.

i. Resident #82 was admitted to the home from October 2014 to February 2015. Upon admission the resident was identified as being frequently incontinent of bladder, required the use of a continence care product, and was placed on a scheduled toileting program. Review of the plan of care did not include a three day continence assessment on admission. Interview with registered staff on March 26, 2015, confirmed that the three day continence assessment should have been completed as per policy, but the DOC of the home was unable to locate the completed assessment. (528)

ii. Resident #17 had a change in bowel continence according to the MDS assessments. In June 2014, the MDS assessment identified the resident as being continent of bowel, in September 2014, the MDS assessment indicated they were noted as usually continent of bowel and in December 2014, the assessment noted as occasionally incontinent of bowel. Discussion with the RAI Coordinator confirmed that this coding would be considered a change in the level continence for this resident. The clinical record did not include a 3 day continence assessment, which was confirmed during a interview with the DOC. The program was not complied with. (168)

iii. Resident #19 had a change in level of continence, an improvement, based on recent MDS assessments. The assessment completed in November 2014, identified the resident as occasionally incontinent of bowels and next assessment completed in February 2015, noted the resident was continent of bowels. Interview with the RAI Coordinator confirmed that the coding identified in the MDS assessment was considered a change in level of continence. A review of the clinical record did not include a 3 day continence assessment, as confirmed by the DOC. The program was not complied with. (168)

E. The home's program, "Fall Interventions Risk Management (FIRM) Program, LTC-E-60", last revised March 2014, identified that "for all falls, a complete clinical assessment will be completed and documented, including vital signs every shift for a minimum of 72 hours".

i. Resident #60 was identified to be at high risk for falls and had six documented falls from July 2014, until March 2015. A review of the clinical record did not include a complete clinical assessment, documented every shift for a minimum of 72 hours, for the fourth and fifth falls sustained by the resident during the identified period of time. The fourth fall was documented as occurring on the night shift; however, there was not a completed clinical assessment documented in the progress notes for the day shift following the incident. The fifth fall was documented as occurring again on the night shift; however, there was not a completed clinical assessment documented in the progress notes for the day shift following the incident. Interview with registered staff, during a review of the clinical record, confirmed that the assessments were not documented as required and confirmed the expectation that documentation be completed, beyond neurological vital signs, every shift for the first 72 hours in the progress notes. (168)

F. The home's policy for "Management of Personal Belongings, LTC-B-110", effective date August 2012, directed staff that "a Client Response Form (CRS) will be initiated for all missing items and a thorough search will be conducted and communicated to the resident/SDM/family". The policy "Management of Concerns/Complaints/Compliments, LP-B-20", last revised October 2014. If concerns could not be resolved immediately, staff were to initiate a Client Service Response (CSR) form and forward it to the ED and the member of the team responsible for managing the concern.

Interview with the DOC identified that the home currently used a Missing Laundry/Article Form for missing items and that this form would be forwarded to her for retention;

however, it was just identified that a CSR form should be used for all missing items that could not be located as this would be considered an unresolved concern.

i. Resident #12 was reported to have had missing hearing aids, on more that one occasion, in the past year. A review of the clinical record confirmed that hearing aids had been missing intermittently since at least December 2014. The DOC was able to provide two initiated Missing Laundry/Article Forms dated December 20, 2014 and March 9, 2015 , for the aids.
ii. Resident #11 reported they recently lost their hearing aids and a review of the clinical record confirmed that they had been missing since December 2014. Interview with the DOC identified that she was not aware of the missing hearing aids as no Missing Laundry/Article Form or CSR form was initiated.
The Concern/Complaints binder and log was reviewed for 2014 and 2015, which was to include all CSR forms. These sources of information did not include any notations regarding the missing hearing aids. Interview with the DOC confirmed that missing personal items should be dealt with according to the policies and that they were not followed. (168) [s. 8. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for the resident set out the planned care for the resident.

A. The plan of care identified resident #40 was identified as high risk for falls. In July 2014, falls committee meeting minutes and clinical progress notes indicated that the resident used a hi/low bed for safety and a posey alarm for falls prevention. Review of the plan of care did not include the use of the hi/low bed or posey alarm. Interview with the DOC confirmed that from July 2014 to the resident's discharge in January 2015, the plan of care did not include the planned care for the resident, related to use of fall

prevention interventions. (585) [s. 6. (1) (a)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A. The plan of care for resident #10 identified that the resident had a history of responsive behaviours, including but not limited to, wandering, verbal and physical aggression, and resistance to care. From August to November 2014, the MDS Quarterly Assessments coded the resident as having an increase in verbal agression, socially inappropriate behaviours, and resistance to care during the Assessment Reference Date (ARD), from "behaviours not exibited in last seven days" to "behaviour of this type occurred one to three days in last seven days". Although there was an increase in behaviours during the ARD when compared to the previous Quarter, the MDS Assessment coded the resident has having "no change" in behaviours symptoms. Interview with the RAI Coordinator confirmed that a change in behaviours was noted during the ARD periods from August to November 2014, but was not identified. The Quaterly MDS Assessments were not integrated with the ARD assessment from direct care staff related to the changes in coding of resident's behaviours from August to November 2014.

B. The plan of care for resident #17 identified that the resident had a history of behaviours, including but not limited to verbal and physical aggression, socially inappropriate behaviours, and resistance to care. The Quarterly MDS Assessment for September 2014, coded the resident as having a decrease in behavioural symptoms related to socially inappropriate behaviours and an increase in behavioural symptoms related to verbal aggression; and in December 2014, the resident was coded to have decrease in behavioural symptoms related to verbal aggression and an increase in behavioural symptoms related to resistance to care. Although the frequency of behaviour symptoms changed during the ARD in September and December 2014, when compared to previous Quarterly Assessments, the MDS assessment identified that the resident had no change in mood and behaviours. Interview with the RAI Coordinator confirmed that the MDS assessment was not consistent with the change in the frequency of behaviours observed by staff during the ARD in September and December 2014.

C. The plan of care for resident #10 identified that the resident had a history of responsive behaviours. An increase in physical behaviours was noted in June 2014, and registered staff documented three incidents of aggression with co-residents. In July

2014, the Physician assessed the resident and only identified one episode of situational aggression and no further episodes. The assessments completed by registered staff and the Physician were not consistent in relation to an increase in physical behaviours in June and July 2014. Interview with registered staff confirmed that the physician assessment did not reflect the assessments by registered staff related to aggressive episodes and therefore, the assessments were not consistent. [s. 6. (4) (a)]

3. 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. In January 2015, resident #10 was assisted to the toilet and left unattended resulting in an unwitnessed fall with no reported injuries. The plan of care for resident #10 identified that the resident was a high risk for falls and interventions directed staff not to leave resident unattended on toilet. Interview with registered staff confirmed that resident should not have been left alone when toileted as specified in the plan of care.

B. The plan of care for resident #18 identified that the resident had impaired respiratory status and required the assistance of staff to apply a Continuous Positive Airway Pressure (CPAP) machine before sleeping. In September 2014, documentation by registered staff indicated that the machine was malfunctioning and was not applied for six evenings. The external vendor was contacted to repair the machine and on assessment noted the machine was functioning well; however, registered staff continued to document the machine was not functioning and not applied for an additional five days. On March 24, 2015, an interview with the representative from the external vendor confirmed the machine was functioning; however, the machine was not being applied regularly as staff didn't know how. In September and October 2014, the resident's CPAP was not applied consistently at night, as outlined in the plan of care.

C. Resident #16 had an injury, prior to admission to the home. This incident was communicated to the physician in December 2014 and as a result some investigation was completed. In February 2015, the resident was reassessed by the physician, at which time, an order was written for a referral to physiotherapy for the injury. A review of the clinical record did not include an assessment by the PT following the physician's order. Interview with the PT identified that he was not aware of the physician's order in February 2015, as he did not receive a referral request and confirmed that as of March 25, 2015, an assessment had not been completed as requested. (168)

D. In July 2014, resident #40 was noted to have increased falls and family of the resident

expressed concerns to the home. As a result, lap belt restraint was ordered by the physician to prevent falls. The resident had a fall three days after the order for the restraint and post fall documentation did not indicate that a lap belt was in use. Review of the written care plan used to direct staff revealed that a lap belt was not included on the plan until eight days after the order and was not included as a kardex task for front line staff to monitor until ten days after the order. The DOC confirmed that there was a delay in the home receiving the belt, and that care set out in the plan was not provided as specified in the resident's plan. (585)

E. The plan of care for resident #18 identified that the resident occasionally required the assistance of staff to get to and from the dining room, and directed staff to apply foot pedals when transporting the resident. On a specified date in March 2015, the resident was transported to the dining room for breakfast and the foot pedals were not in place. Interview with direct care staff confirmed that the foot pedals were not in place during the transport to the dining room, as outlined in the plan of care.

F. The plan of care for resident #83 outlined the resident's preference to have meals served all at once by directing staff to ensure that all meal items were served at the same time. During lunch on a specified date in March 2015, the resident was observed to be served their appetizer first, followed by the entree and dessert. Interview with staff serving the resident confirmed they were aware of the resident's preferences but continued to serve the resident their appetizer separately. The care was not provided to the resident as specified in the plan, related to the resident's preferences at mealtimes.

G. On a specified date in March 2015, resident #14 was observed reclined in a tilted wheelchair. A review of the clinical record identified the device and included an intervention to reposition the resident every two hours. The resident was observed seated in the chair beginning at 1802 hours, until 2120 hours and was not observed to be repositioned. The resident received nourishment at 1958 hours and medications at 2106 hours; however, was not repositioned during these interactions. At 2120 hours, the resident was approached by a PSW who indicated that they would be providing care. The PSW confirmed that the resident should be repositioned every two hours. The resident was not provided care as per the plan of care. (168)

H. On March 19, 2015, resident #65 was observed to be seated in a reclined position in a tilted wheelchair. A review of the clinical record identified the device and included an intervention to reposition the resident every two hours. The resident was observed in the chair beginning at 1802 hours, until 2132 hours and was not observed to be repositioned.

The resident received nourishment at 2003 hours; however, was not repositioned at that time. At 2132 hours, the resident was approached by the PSW at which time they agreed to go to bed and the chair tilt was reduced to porter the resident. Interview with the PSW identified that the resident will resist repositioning at times, but should attempt to be repositioned every two hours. The resident was not provided care as per the plan of care. (168)

I. Upon admission, in late 2014, resident #82 had an interdisciplinary progress note that stated the resident was not to have milk to drink or in their cereal, as it caused increase phlegm. Documentation provided by the home revealed that soy milk was not available for the resident six days and three months after admission. The DOC and Food Service Manager (FSM) confirmed that there were times when soy milk was not available for the resident, as per their plan of care. (585) [s. 6. (7)]

4. The licensee failed to ensure when a resident is reassessed and the plan of care reviewed and revised, if the plan 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.

In May 2014, resident #40 was identified as being at medium risk for falls, The plan of care identified that the resident required extensive assistance with toileting safety with one person assistance for transfers.

i. After a fall in May 2014, Post Fall Assessment Documentation form described that the resident was transferring out of bed, probably attempting to go to the bathroom, and noted under interventions to prevent recurrence 'an email sent for a proper alarm'. The following day a progress note from registered staff identified a floor mat was requested.
ii. In June 2014, the resident had a fall with no injury. The Post Fall Assessment Documentation form did not indicate whether the falls prevention interventions (an alarm and falls mat) were in use or effective, nor did it include any new interventions to prevent recurrence.
iii. In July 2014, the resident had three falls, two falls did not identify if falls interventions were in place a the time of the falls, or whether they were effective. Additional interventions after the first fall included one hour checks and a lap restraint after the third fall. After a fourth fall in July 2014, the post falls dcumentation did not specify what interventions were in place or if they were effective.
iv. The written plan of care was not revised to include falls interventions bed/chair alarm and falls mat until two months after they were identified, and the eight days after the lap

belt was ordered.
v. The DOC reported that the lap restraint was put on order and there was a delay of several days before the home received the belt. The DOC confirmed that while post fall assessment documents were being completed by staff, interventions should have been considered and included when the care set out in the resident's plan of care had been ineffective. (585) [s. 6. (11) (b)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the following:
i. that the written plan of care for the resident sets out the planned care for the resident
ii. that different approaches are considered in the revision of the plan of care, when the plan has not been effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a PASD under subsection (3) to assist the resident with routine activity of living was included in a resident's plan of care only with the following aspects satisfied:
1. Alternatives to the use of a PASD were considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living,
2. The use of the PASD was reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living,
3. The use of the PASD was approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations.

A. The plan of care for resident #14 indicated the resident required a tilt wheelchair for comfort and positioning as a personal assistive services device (PASD). Interviews were held with multiple PSW's who were unable to report how long the resident had a tilt chair. In interviews with registered staff it was confirmed that the tilt wheelchair was used for comfort and positioning. Review of the plan of care did not include an assessment for use of the PASD, including considerations for alternatives to the use of a PASD, the use of the PASD, and approval from staff in accordance to s. 33(4)3. Interview with the PT confirmed that a formalized assessment was not completed. (585)

B) Resident #20 had a tilt wheelchair in their plan of care for comfort and positioning, effective October 6, 2014. This documentation was made by an unregulated health care provider. Multiple PSW's were interviewed, and said the tilt chair was used for comfort and positioning. Review of the plan of care did not include an assessment for the use of the PASD, including considerations for alternatives to the use of a PASD, the use of the PASD, and approval from staff in accordance to s. 33(4)3. Interview with the PT confirmed that an assessment for use of the PASD was not completed. [s. 33. (4) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the use of a PASD under subsection (3) to assist the resident with routine activity of living is included in a resident's plan of care only with the following aspects satisfied:
1. Alternatives to the use of a PASD were considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living,
2. The use of the PASD was reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living,
3. The use of the PASD was approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 35. Prohibited devices that limit movement
Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident; or
(b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement. 2007, c. 8, s. 35.

Findings/Faits saillants :

1. The licensee failed to ensure that no device provided for in the regulations was used on a resident, to restrain the resident.

Ontario Regulation 79/10 section 112(7) indicates that "for the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home: sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose".

Resident #60 was a high falls risk and documentation indicated they sustained six falls from July 2014, to March 2015. According to the clinical record following the third fall during the identified period of time, the resident was restrained using a prohibited device, a blanket, for approximately three hours, as there were no approved devices available. Interview with two registered staff confirmed the use of linen, tied around the resident and then the wheelchair, for a short period of time on the evening and night shift on an identified date. Interview with the DOC confirmed that the staff acknowledged the use of the device, a tied blanket, as a short term measure to restraint. (168) [s. 35. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no device provided for the in the regulation is used on a resident to restrain the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident has fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls.

In November 2014, resident #40 had a fall that which resulted in a fracture. Review of clinical records did not include a post-fall assessment using a clinically appropriate assessment tool. The DOC reported that the home's Post Fall Assessment Documentation form should have been completed. The home was unable to produce a Post Fall Assessment Documentation form for the fall. (585) [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the resident has fallen, a post-fall assessment is conducted using a clinically appropriate assessment instrument specifically designed for falls, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. In December 2014, resident #10 was noted to have a new area of skin breakdown and required ongoing treatment. Review of the plan of care did not include weekly assessments of the wounds after December 22, 2014. Interview with the Wound Care Champ confirmed that weekly assessments were not included in the plan of care after December 22, 2014, for two and a half months, at which time the wound was healed.

B. In March 2015, registered staff identified that resident #12 had a new skin tear. Review of the plan of care included an initial assessment and referral to the RD but did not include weekly assessments for three weeks. Interview with the Wound Care Champ identified that weekly wound assessments had not been completed for three weeks following initial assessment for resident #12. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #7: 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 the actions taken to meet the needs of the resident with responsive behaviours included assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

A. The plan of care for resident # 10 identified that the resident had a history of responsive behaviours, including but not limited to, physcial and verbal aggression.
i. From June 2014 to July 2014, the resident had an increase is aggression with six documented incidents by registered staff. Demenita Observation System (DOS) monitoring was initiated after each incident; however, review of the records identified they were not completed. Interview with registered staff and DOC confirmed the DOS monitoring was not consistently completed by staff following incidents in June and July 2014.
ii. In March 2015, the resident was assessed by Beahvioural Supports Ontario (BSO) and ongoing DOS monitoring was recommended; however, was not consistently completed by staff. Documentation from BSO five days later confirmed DOS monitoring was incomplete and requested monitoring to be completed by staff for a second time. Interview with registered staff on March 19, 2015, confirmed DOS charting was incomplete and the behaviours were not documented every half hour. (528)

B. Resident #17 demonstrated a responsive behaviour in February 2015. As a result of this behaviour staff were instructed to complete Dementia Observation System (DOS) charting. A review of the DOS records for February 2015, identified that the documentation was not complete. The DOC reviewed the identified DOS records and confirmed that the documentation was not completed as required. (168) [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 to ensure that the actions taken to meet the needs of the resident with responsive behaviours includes assessment, reassessments, interventions, and documentation of the resident's responses to the interventions, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents

Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,

(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and

(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

The plan of care for resident #10 identified that the resident had a history of responsive behaviours, including but not limited to, intermittent physical and verbal aggression. In an interview with the DOC it was confirmed that the resident required one to one staffing when an increase in behaviours were noted.
i. In June 2014, resident #10 had an increase in physical behaviours and was involved in an altercation with a co-resident resulting in injury. One to one monitoring was put in place for two days only. Over the next four weeks, registered staff documented five incidents of resident to resident aggression involving resident #10 with no injuries noted. The home did not take steps to minimize the risk of altercations and potentially harmful interactions between residents when they did not provide additional monitoring for resident #10 until four weeks after behaviours increased, during which time, five altercations with potential harmful interactions occurred.
B. In March 2015, resident #10 displayed an increase in physical behaviours towards co-residents. An initial incident included resident to resident altercation with no injuries noted. Review of the incident included a note from the DOC, stating that if aggressive behaviours continued to be observed, one to one staffing would be put in place. The week following the incident, registered staffing documented the resident was "calling out and aggessive at times". The following week resident #10 was involved in a second incident of aggression, resulting in co-resident injury. Interview with the DOC confirmed that one to one was not put in place for resident #10 following ongoing aggression following the initial incident in March 2015. The resident had one additional incident in March 2015 of aggression towards co-resident, at which time, one to one was initiated. Steps were not taken to minimize the risk of altercation and potentially harmful interactions between resident #10 and co-residents following an increase in aggressive behaviours in June and July 2014 and March 2015. [s. 54. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

Throughout the course of the inspection, bathrooms for resident #12 and resident #14 were noted to have lingering offensive odors. Interview with direct care staff confirmed the odours are usually present and staff were aware. Housekeeping staff identified interventions in place to try and minimize the odours, which were ineffective. The home was unable to find a formalized procedure for addressing incidents of lingering offensive odors. [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #10: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that when restraining of a resident by a physical device under section 31 or section 36 of the Act, that 1. Staff apply the physical device in accordance with any manufacturer's instructions.

On March 16, 2015, resident #80 was observed in the afternoon in a tilted wheelchair with lap belt applied loose, approximately four fingers breadth away from the resident`s body. Review of the plan of care and interview with registered staff confirmed that the resident required the use of the lap belt as a restraint. Interview with direct care staff confirmed the lap belt was applied loosely and was tightened as per manufacturers instructions.(585) [s. 110. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when restraining of a resident by a physical device under section 31 or section 36 of the Act, the staff apply the physical device in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD used under section 33 of the Act is applied by staff in accordance with any manufacturer's instructions.

i. On a specified date in March 2015, resident #18 was seated in their wheelchair with a front fastening seatbelt that was loose, approximately five fingers breadth away from the resident's body.
Review of the plan of care indicated that the resident required the front fastening seatbelt when in the wheelchair. It was identified that the resident often undid the belt and if so, staff were to monitor and fasten the belt.Interview with registered staff identified that the resident could not always undo the belt and required the belt to be fastened when in the wheelchair. Registered staff confirmed that the belt was too loose and was immediately tightened to two fingers breadth away from the resident's body.

ii. On a specified date in March 2015, resident #62 was observed with a loose lap belt at 1345 hours. The PSW reported the belt should be applied with a finger or two space between the resident and the belt, and confirmed the belt was not applied according to manufacturer's specifications. Registered staff confirmed the resident had a lap belt as a PASD. (585)

iii. On a specified date in March 2015, at 1448 hours, resident #64 was observed to be wearing a front fastening seat belt which was loose fitting. The distance between the resident and the belt was approximately five inches when pulled away from the abdomen. Interview with registered staff identified that the device was a PASD, as the resident was able to remove it independently. The staff member also identified that he had not received education specifically regarding the application of the belt. The belt was not applied according to manufacturer's specifications. Interview with the DOC on March 20, 2015, confirmed that to the best of her knowledge, the home's did not have information regarding manufacturer's instructions for the application of seat belts readily available. (168) [s. 111. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a PASD used under section 33 of the Act is applied by staff in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

During the course of the inspection, the water taps on the sinks in resident bathrooms were observed to be covered in a white precipitate in room #'s 304, 306, 311, 312, 315, and 330. Interview with the ESM confirmed that the home was aware of the water taps in the resident's bathrooms, which needed to be replaced. [s. 15. (2) (c)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 that promoted zero tolerance of abuse and neglect of residents was complied with.

The home's procedure "Resident Non-Abuse- Ontario, LP-C-20-ON", last revised September 2014, identified that:
a. "Any staff member or person who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a resident must immediately report that suspicion and the information on which it is based to the Executive Director (ED) of the home or, if unavailable, to the most senior supervisor on the shift at that time"
b. "The first priority is the ensure the safety and comfort of the abuse victim(s), first taking all reasonable steps to provide for their immediate safety and well being, then through completion of full assessments, a determination of the resident's needs and a documented plan to meet those needs".

In 2014, the DOC became aware of allegations of abuse involving resident #61, #62 and #63 approximately nine days after the alleged incidents occurred.
Interview with the DOC and staff who reported the allegations confirmed that the incidents were not reported immediately. The staff member, who reported the incident, identified that an attempt was made to speak with the DOC two days following the incidents via telephone; however, the message that was left was vague in nature and no call back was received. The staff member then visited the DOC nine days following the incidents to report the allegations.
A review of the clinical records for the identified residents did not include a complete full assessment of the residents following the allegation, as identified in the procedure.
i. Resident #62 was to have a head to toe assessment, as part of the full assessment, to be completed once the allegation of abuse was identified. A review of the clinical did not include a head to toe assessment, as confirmed during an interview with the DOC.
ii. Resident #63, who was cognitively well, was not interviewed following the allegation of abuse, nor was there a notation in the record, regarding the allegation until the internal investigation had been completed, as verified by the DOC. (168) [s. 20. (1)]

WN #14: 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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included all identified responsive behaviours.

Resident #17 demonstrated the responsive behaviour of refusal and resistance to care, specifically medications and treatments, which was well documented in the clinical record and Medication Administration Records for at least the last three months. The MDS assessment fro December 2014, identified an increase in the frequency of the behaviour, the physician was notified and changes were made to medication and treatment orders as a result. A review of the plan of care on March 26, 2015, did not include a focus statement or the identification of the specific behaviour, as confirmed during an interview with the DOC. (168) [s. 26. (3) 5.]

WN #15: 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 ensured 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.

The plan of care for resident #18 identified that the resident had chronic respiratory disease and required continuous oxygen therapy. Review of the electronic treatment administration record (eTAR), included monitoring of the resident every shift to ensure the their oxygen saturation was over ninety percent. In September and October 2014, ten different shifts did not document the resident's oxygen saturation and in January 2015, six shifts did not document the resident's oxygen saturation. Interview with registered staff confirmed that staff were checking oxygen saturation but were not documenting findings. [s. 30. (2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident received fingernail care, including cutting of fingernails.

On March 16, 19 and 24, 2015, resident #22 was observed to have long, untrimmed, unclean fingernails. The plan of care for resident # 22 indicated that the resident received baths on Monday and Friday evenings, at which time, hair is washed and hands are manicured. Interview with direct care staff caring for the resident confirmed that although the resident was bathed on the previous day, nails were untrimmed and unclean, and nail care was not provided. [s. 35. (2)]

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

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the weekly menu was communicated to residents.

For the week of March 16 to 22nd, 2015, the home was on week 1 of their menu cycle. On March 16, 2015, during lunch meal service, the week 2 menu was posted, and did not reflect what was served to residents and what was posted on the daily menu. The week 2 menu continued to be observed posted on March 17, 18, and 19, 2015. The Food Service Manager confirmed the correct weekly menu should have been posted during week 1. (585) [s. 73. (1) 1.]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the advice of the Residents' Council was sought out in developing and carrying out the satisfaction survey, and in acting on its results.

Review of Resident Council Minutes from 2014 and 2015, did not include any evidence that the home sought out advice of the Council in developing and carrying out the satisfaction survey. Interview with Director of Recreation confirmed that the Council has never been included in the development of the satisfaction survey; however, would be included in the next meeting. [s. 85. (3)]

WN #19: 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. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

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:

4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The license failed to ensure that where an incident occurred that caused an injury to a resident for which the resident is taken to a hospital, but the licensee was unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, (b) where the licensee remained unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

In November 2014, resident #40 fell, which resulted in a fracture. A Critical Incident System report was not submitted to the the Director until four days later. This was confirmed by the DOC. [s. 107. (3.1) (b)]

2. The licensee who was required to inform the Director of an incident under subsection (1), (3) or (3.1) failed to, 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: 4. Analysis and follow-up action, including, i. the immediate actions that have been taken to prevent recurrence.

Resident #040 was identified as being at risk for falls.

A) In July 2014, resident #040, who was identified as being at risk for falls, fell, which resulted in injury to the head and transfer to hospital. A CIS report regarding the fall was not submitted until two days later, and did not indicate immediate actions that were taken to prevent recurrence.
In between the fall and submission of the CIS report, the resident had returned from the hospital and experienced another fall in the home, which resulted in injury to the head and transfer to the hospital. The DOC confirmed that the CIS report did not identify any immediate actions that were taken to prevent recurrence.

B) In November 2015, the resident fell, which resulted in a fracture and transfer to hospital. A CIS report submitted four days later did not indicate any immediate actions that were taken to prevent recurrence. This was confirmed by the DOC. (585) [s. 107. (4) 4. i.]

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

Findings/Faits saillants :

1. The licensee failed to ensure that an analysis of the restraining of residents by use of a physical device was undertaken on a monthly basis.

Interview with the the DOC on March 25, 2015, confirmed that the home did not consistently complete, on a monthly basis, a formalized analysis of the restraining of residents by the use of a physical device on a monthly basis. The DOC was not able to provided the records on request. (168) [s. 113. (a)]

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 6th day of May, 2015

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
C DiTomasso #528

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CYNTHIA DITOMASSO (528), LEAH CURLE (585), LISA VINK (168)
Inspection No. / No de l'inspection :	2015_267528_0010
Log No. / Registre no:	H-001829-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 13, 2015
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	BRIERWOOD GARDENS 425 PARK ROAD NORTH, BRANTFORD, ON, N3R-7G5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debbie Boakes

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

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_322156_0014, CO #002;

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 ensure that the following plan, policy, protocol, procedure, strategy or system are complied with:

i. Transfers, LTC-B-70
ii. PASD/Assistive Devices, Policy LTC-J-30
iii. Pain Assessment and Symptom Management, LTC-E-80
iv. Continence Care, LTC-E-50
v. Fall Interventions Risk Management (FIRM) Program, LTC-E-60
vi Management of Personal Belongings, LTC-B-110

Grounds / Motifs :

1. Previously issued as a CO July and November 2014.

The licensee failed to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

A. The home's policy "Transfers, LTC-B-70", last revised August 2012, directed staff to communicate reasons for hospital transfers and details to the resident/substitute decision maker (SDM)/family.

i. In September 2014, the substitute decision maker (SDM) for resident #18

called emergency services from outside of the home and an ambulance was sent to the home to check on the resident. The resident was subsequently transferred to the hospital for assessment. Review of the plan of care did not include any documentation that the home notified the SDM of the transfer until the following day when the SDM called the home to enquire about the resident's status. Interview with registered staff confirmed that the SDM was not notified at the time of the resident's transfer to hospital and any details, as outlined in the policy.

B. The home's policy, "PASD/Assistive Devices, Policy LTC-J-30", last revised August 2012, stated that consent for a Personal Assistance Services Device (PASD)/Assistive Device will be obtained and documented in interdisciplinary progress notes and documentation will be completed every shift on the use of the PASD/Assistive Device.

i. The plan of care for resident #14 identified that the resident required a tilt chair for comfort and positioning. Review of documentation did not include any consent from the SDM. Interview with the Restorative Care Aide confirmed that consent was obtained by the resident's SDM, however, was not documented in the interdisciplinary progress notes.
ii. Further review of resident #14 on March 19, 2015, did not include documentation on the use of the PASD, which was confirmed by registered staff. (585)

C. The Home's program "Pain Assessment and Symptom Management, LTC-E-80", last revised August 2012, directed the Nurse to review MDS assessment related to pain (sections J2 and J3), and review the Resident's outcomes, RAPs will be completed to determine the need for additional pain assessment and monitoring and/or additional referral.
The policy further identified that:
1. "If the resident complains of pain, a quick pain assessment on the resident will be completed using PQRST and documented";
2. "The resident's pain will be measured using a standardized, evidenced-informed clinical tool",
3. that staff will initiate a pain monitoring tool when "PRN medication is used for 3 consecutive days", and
4. that staff will initiated a pain monitoring tool when "a new regular pain medication is ordered".

i. Resident #16 had an area of altered skin integrity in December 2014, which resulted in pain and as needed (PRN) analgesic use. The clinical record did not include a completed pain assessment with the reports of new pain, the altered skin integrity, which was confirmed by registered staff during a record review. A review of the Medication Administration Records (MAR) and progress notes identified that the resident consecutively used as needed analgesic in December 2014 and January 2015. The clinical record did not include any pain monitoring tools completed for the identified periods of time, as confirmed by registered staff during a record review. Registered staff confirmed the program expectations for the completion of a pain assessment and pain monitoring tools; however, confirmed that these would be maintained in the resident's record, if completed and could not be located. (168)

ii. Resident #19 voiced concern of pain in the lower extremities in February 2015. This pain was communicated to the physician who ordered an analgesic to be administered routinely at bedtime. A review of the clinical record did not show that a pain monitoring tool had been initiated when the new regular pain medication was ordered, as confirmed during a record review by the DOC. The program was not complied with. (168)
iii. The plan of care for resident #18 identified that the resident was receiving regular pain medication for pain related to arthritis. In September 2014, the resident had an increase in pain resulting in a change in the frequency of regular scheduled pain medication. Review of the plan of care did not include a pain monitoring tool after a change in regularly scheduled pain medication. Interview with two registered staff confirmed that the resident's responses and effectiveness of the change in pain medication was not monitored and documented using the pain monitoring tool, as outlined in the policy. (528)
iv. The plan of care for resident #10 identified that the resident had moderate pain less than daily and was receiving a non-steroidal anti-inflammatory regularly. An increase in responsive behaviours was noted in June 2014 and additional pain medication was ordered, to be administered on an as needed basis. In August 2014, the regular anti-inflammatory pain medication was changed to a long acting controlled substance. A care conference held in August 2014, identified that pain may be a contributing factor to the increase in the resident's behavours. Review of the plan of care did not include any pain monitoring tool after pain medications were changed in June or August 2014. During an interview with registered staff on March 19, 2015, it was confirmed that the pain monitoring tool should be completed following a change in pain medications to evaluate the effectiveness of the drugs. Interview with the DOC,

confirmed the pain monitoring tool was not completed for resident #10 following changes in pain medications in June and August 2014, as outlined in the policy. (528)

D. The home's Policy for "Continence Care, LTC-E-50", last revised May 2013, directed staff to initiate a three day continence assessment on admission and or if there is a change in level of continence.

i. Resident #82 was admitted to the home from October 2014 to February 2015. Upon admission the resident was identified as being frequently incontinent of bladder, required the use of a continence care product, and was placed on a scheduled toileting program. Review of the plan of care did not include a three day continence assessment on admission. Interview with registered staff on March 26, 2015, confirmed that the three day continence assessment should have been completed as per policy, but the DOC of the home was unable to locate the completed assessment. (528)

ii. Resident #17 had a change in bowel continence according to the MDS assessments. During the MDS assessment for June 2014, the resident was identified as being continent of bowel, the assessment from September 2014, they were noted as usually continent of bowel and in December 2014, the assessment noted the resident as occasionally incontinent of bowel. Discussion with the RAI Coordinator confirmed that this coding would be considered a change in the level continence for this resident. The clinical record did not include a 3 day continence assessment, which was confirmed during a interview with the DOC. The program was not complied with. (168)

iii. Resident #19 had a change in level of continence, an improvement, based on recent MDS assessments. The assessment completed in November 2014, identified the resident as occasionally incontinent of bowels and next assessment completed in February 2015, noted the resident was continent of bowels. Interview with the RAI Coordinator confirmed that the coding identified in the MDS assessment was considered a change in level of continence. A review of the clinical record did not include a 3 day continence assessment, as confirmed by the DOC. The program was not complied with. (168)

E. The home's program, "Fall Interventions Risk Management (FIRM) Program, LTC-E-60", last revised March 2014, identified that "for all falls, a complete clinical assessment will be completed and documented, including vital signs

every shift for a minimum of 72 hours".

i. Resident #60 was identified to be at high risk for falls and had six documented falls from July 2014, until March 2015. A review of the clinical record did not include a complete clinical assessment, documented every shift for a minimum of 72 hours, for the fourth and fifth falls sustained by the resident during the identified period of time. The fourth fall was documented as occurring on the night shift; however, there was not a completed clinical assessment documented in the progress notes for the day shift following the incident. The fifth fall was documented as occurring again on the night shift; however, there was not a completed clinical assessment documented in the progress notes for the day shift following the incident. Interview with registered staff, during a review of the clinical record, confirmed that the assessments were not documented as required and confirmed the expectation that documentation be completed, beyond neurological vital signs, every shift for the first 72 hours in the progress notes. (168)

F. The home's policy for "Management of Personal Belongings, LTC-B-110", effective date August 2012, directed staff that "a Client Response Form (CRS) will be initiated for all missing items and a thorough search will be conducted and communicated to the resident/SDM/family". The policy "Management of Concerns/Complaints/Compliments, LP-B-20", last revised October 2014, directed staff that if concerns could not be resolved immediately, staff were to initiate a Client Service Response (CSR) form and forward it to the ED and the member of the team responsible for managing the concern.

Interview with the DOC identified that the home currently used a Missing Laundry/Article Form for missing items and that this form would be forwarded to her for retention; however, it was just identified that a CSR form should be used for all missing items that could not be located as this would be considered an unresolved concern.

i. Resident #12 was reported to have had missing hearing aids, on more that one occasion, in the past year. A review of the clinical record confirmed that hearing aids had been missing intermittently since at least December 2014. The DOC was able to provide two initiated Missing Laundry/Article Forms dated December 20, 2014 and March 9, 2015, for the aids.
ii. Resident #11 reported they recently lost their hearing aids and a review of the clinical record confirmed that they had been missing since December 2014.

Interview with the DOC identified that she was not aware of the missing hearing aids as no Missing Laundry/Article Form or CSR form was initiated.
The Concern/Complaints binder and log was reviewed for 2014 and 2015, which was to include all CSR forms. These sources of information did not include any notations regarding the missing hearing aids. Interview with the DOC confirmed that missing personal items should be dealt with according to the policies and that they were not followed. (168) (585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 25, 2015

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

Linked to Existing Order / Lien vers ordre existant: 2014_240506_0016, CO #003;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare submit and implement a plan for achieving compliance to ensure staff and others involved in the different aspects of care collaborat with each other in the assessment of all residents, including but not limited to, residents #10 and #17 so that their assessments are integrated, consistent with and complement each other, related to responsive behaviours.

The plan shall be emailed to Cynthia.Ditomasso@ontario.ca by May 4, 2015.
The plan shall be fully implemented by: May 25, 2015.

Grounds / Motifs :

1. This order was previously issued in July and November 2014.

The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A. The plan of care for resident #10 identified that the resident had a history of responsive behaviours, including but not limited to, wandering, verbal and physical aggression, and resistance to care. From August to November 2014,

the MDS Quarterly Assessments coded the resident as having an increase in verbal agression, socially inappropriate behaviours, and resistance to care during the Assessment Reference Date (ARD), from "behaviours not exibited in last seven days" to "behaviour of this type occurred one to three days in last seven days". Although there was an increase in behaviours during the ARD when compared to the previous Quarter, the MDS Assessment coded the resident has having "no change" in behaviours symptoms. Interview with the RAI Coordinator confirmed that a change in behaviours was noted during the ARD periods from August to November 2014, but was not identified. The Quaterly MDS Assessments were not integrated with the ARD assessment from direct care staff related to the changes in coding of resident's behaviours from August to November 2014.

B. The plan of care for resident #17 identified that the resident had a history of behaviours, including but not limited to verbal and physical aggression, socially inappropriate behaviours, and resistance to care. The Quarterly MDS Assessment for September 2014, coded the resident as having a decrease in behavioural symptoms related to socially inappropriate behaviours and an increase in behavioural symptoms related to verbal aggression; and in December 2014, the resident was coded to have decrease in behavioural symptoms related to verbal aggression and an increase in behavioural symptoms related to resistance to care. Although the frequency of behaviour symptoms changed during the ARD in September and December 2014, when compared to previous Quarterly Assessments, the MDS assessment identified that the resident had no change in mood and behaviours. Interview with the RAI Coordinator confirmed that the MDS assessment was not consistent with the change in the frequency of behaviours observed by staff during the ARD in September and December 2014.

C. The plan of care for resident #10 identified that the resident had a history of responsive behaviours. An increase in physical behaviours was noted in June 2014, and registered staff documented three incidents of aggression with co-residents. In July 2014, the Physician assessed the resident and only identified one episode of situational aggression and no further episodes. The assessments completed by registered staff and the Physician were not consistent in relation to an increase in physical behaviours in June and July 2014. Interview with registered staff confirmed that the physician assessment did not reflect the assessments by registered staff related to aggressive episodes and therefore, the assessments were not consistent. (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 25, 2015

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2014_322156_0014, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare submit and implement a plan for achieving compliance to ensure that the plan of care for all residents, including but not limited to, residents #10, #14, #16, #18, #40, #65, #82, #83 are provided to the resident as specified in the plan, within relation to fall prevention interventions, physician orders, safe transporting, meal preferences, and turning and repositioning.

The plan shall be emailed to Cynthia.DiTomasso@ontario.ca by May 4, 2015.
The plan shall be fully implemented by: May 25, 2015.

Grounds / Motifs :

1. Previously issued as a CO November 2013, March 2014, May 2014, July 2014 and November 2014.

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. In January 2015, resident #10 was assisted to the toilet and left unattended resulting in an unwitnessed fall with no reported injuries. The plan of care for resident #10 identified that the resident was a high risk for falls and interventions directed staff "not to leave resident unattended on toilet". Interview with registered staff confirmed that resident should not have been left alone when toileted as specified in the plan of care.

B. The plan of care for resident #18 identified that the resident had impaired

respiratory status and required the assistance of staff to apply a Continuous Positive Airway Pressure (CPAP) machine before sleeping. In September 2014, documentation by registered staff indicated that the machine was malfunctioning and was not applied for six evenings. The external vendor was contacted to repair the machine and on assessment noted the machine was functioning well; however, registered staff continued to document the machine was not functioning and not applied for an additional five days. On March 24, 2015, an interview with the representative from the external vendor confirmed the machine was functioning; however, the machine was not being applied regularly as staff didn't know how. In September and October 2014, the resident's CPAP was not applied consistently at night, as outlined in the plan of care.

C. Resident #16 had an injury, prior to admission to the home. This incident was communicated to the physician in December 2014 and as a result some investigation was completed. In February 2015, the resident was reassessed by the physician, at which time, an order was written for a referral to physiotherapy for the injury. A review of the clinical record did not include an assessment by the PT following the physician's order. Interview with the PT identified that he was not aware of the physician's order in February 2015, as he did not receive a referral request and confirmed that as of March 25, 2015, an assessment had not been completed as requested. (168)

D. In July 2014, resident #40 was noted to have increased falls and family of the resident expressed concerns to the home. As a result, lap belt restraint was ordered by the physician to prevent falls. The resident had a fall three days after the order for the restraint and post fall documentation did not indicate that a lap belt was in use. Review of the written care plan used to direct staff revealed that a lap belt was not included on the plan until eight days after the order and was not included as a kardex task for front line staff to monitor until ten days after the order. The DOC confirmed that there was a delay in the home receiving the belt, and that care set out in the plan was not provided as specified in the resident's plan. (585)

E. The plan of care for resident #18 identified that the resident ocaisionally required the assistance of staff to get to and from the dining room, and directed staff to apply foot pedals when transporting the resident. On a specified date in March 2015, the resident was transported to the dining room for breakfast and the foot pedals were not in place. Interview with direct care staff confirmed that the foot pedals were not in place during the transport to the dining room, as

outlined in the plan of care.

F. The plan of care for resident #83 outlined the resident's preference to have meals served all at once by directing staff to ensure that all meal items were served at the same time. During lunch on a specified date in March 2015, the resident was observed to be served their appetizer first, followed by the entree and dessert. Interview with staff serving the resident confirmed they were aware of the resident's preferences but continued to serve the resident their appetizer separately. The care was not provided to the resident as specified in the plan, related to the resident's preferences at mealtimes.

G. On a specified date in March 2015, resident #14 was observed reclined in a tilted wheelchair. A review of the clinical record identified the device and included an intervention to reposition the resident every two hours. The resident was observed seated in the chair beginning at 1802 hours, until 2120 hours and was not observed to be repositioned. The resident received nourishment at 1958 hours and medications at 2106 hours; however, was not repositioned during these interactions. At 2120 hours, the resident was approached by a PSW who indicated that they would be providing care. The PSW confirmed that the resident should be repositioned every two hours. The resident was not provided care as per the plan of care. (168)

H. On a specified date in March 2015, resident #65 was observed to be seated in a reclined position in a tilted wheelchair. A review of the clinical record identified the device and included an intervention to reposition the resident every two hours. The resident was observed in the chair beginning at 1802 hours, until 2132 hours and was not observed to be repositioned. The resident received nourishment at 2003 hours; however, was not repositioned at that time. At 2132 hours, the resident was approached by the PSW at which time they agreed to go to bed and the chair tilt was reduced to porter the resident. Interview with the PSW identified that the resident will resist repositioning at times, but should attempt to be repositioned every two hours. The resident was not provided care as per the plan of care. (168)

I. Upon admission, in late 2014, resident #82 had an interdisciplinary progress note that stated the resident was not to have milk to drink or in their cereal, as it caused increase phlegm. Documentation provided by the home revealed that soy milk was not available for the resident six days after admission and three months after admission. The DOC and Food Service Manager (FSM) confirmed

that there were times when soy milk was not available for the resident, as per their plan of care. (585) (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 25, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

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

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

Issued on this 13th day of April, 2015

Signature of Inspector / Signature de l'inspecteur : C DiTomasso #528

Name of Inspector / Nom de l'inspecteur : Cynthia DiTomasso

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