Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 22, 2018	2018_544527_0001	006294-17	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Erin Meadows
2930 Erin Centre Boulevard MISSISSAUGA ON L5M 7M4

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

KATHLEEN MILLAR (527), LEAH CURLE (585), MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17 and 18, 2018.

During the course of this inspection, the following additional inspections were conducted:

Complaint #001670-17 related to insufficient staffing.

Critical Incidents (CI):

CI #015848-16 related to an injury;
CI #023768-16 related to improper care;
CI #028786-16 related to alleged staff to resident abuse;
CI #034608-16 related to alleged resident to resident abuse;
CI #000078-17 related to alleged resident to resident abuse;
CI #001011-17 related to improper transferring;
CI #001749-17 related to a medication incident;
CI #003257-17 related to alleged resident to resident abuse;
CI #009626-17 related to improper care; and
CI #025962-17 related to a fall.

Onsite Inquiries:
Log #004470-16 related to alleged staff to resident abuse;
Log #008313-16 related to alleged staff to resident abuse;
Log #012910-16 related to alleged staff to resident abuse;
Log #017189-16 related to alleged staff to resident abuse;
Log #023784-17 related to alleged resident to resident abuse;
Log #024575-17 related to alleged resident to resident abuse;
Log #028364-17 related to alleged staff to resident abuse;
Log #007932-17 related to alleged staff to resident abuse;
Log #002770-17 related to continence care; and
Log #015868-17 related to a fall.

During the course of the inspection, the inspector(s) spoke with the General Manager, Acting Director of Nursing Care (DONC), Assistant Director of Nursing Care (ADNC), the Kinesiologist, the Physiotherapist (PT), the Physiotherapy Aides (PTA), the Neighbourhood Coordinators (NC), Director of Recreation, Director of Environmental Services, housekeeping aides, Registered Dietitian (RD), Resident Assessment Instrument / Quality Improvement (RAI/QI) Coordinator, Director of Food Services, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Aides (PCA) and Residents and Residents` Family Members.

During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home, and reviewed relevant documents including but not limited to meeting minutes, policy and procedures, investigative notes, training information and clinical health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **7 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out, the planned care for the resident.

The clinical record of resident #023 was reviewed including the written plan of care and progress notes. They indicated that during the provision of care on a specific date in

November 2017, the resident had a fall. The resident suffered injury during the specific care. Review of the resident's clinical record indicated that during the specific care, staff were to ensure that the resident was positioned correctly. The interventions related to proper positioning of the resident during the care was not included in the written plan of care.
The home's records were reviewed including Critical Incident (CI) #2881-000021-17 and the investigation records and they included information as above.
Personal Care Aide (PCA) #152, Registered Practical Nurse (RPN) #102 and the Physiotherapist (PT) were interviewed. They confirmed that the resident required specific positioning during the provision of the identified care.
The PT reviewed the written plan of care and confirmed that the information related to the resident's need for proper positioning during the specific care was not included in their care plan.

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

Resident #006 was observed on three specific dates in January 2018, with a device applied while using a mobility aid.
The home's policy called "Restraint and PASD Procedures in LTC", number 04-52, and effective June 2017, directed registered staff to complete a Personal Assistive Services Device (PASD) assessment on the "Alternatives to Restraint / PASD Assessment" form in Point Click Care (PCC) on a quarterly basis.
The plan of care was reviewed, which confirmed the resident required a specific assistive device. There was no PASD quarterly assessment completed for the device by the registered staff in the clinical record.
RN #126 was interviewed and was unable to locate the PASD assessment for the resident's assistive device and indicated that they were expected to complete the PASD assessment before they use the PASD and then quarterly.
The Neighbourhood Coordinator (NC) #117 was interviewed and also confirmed that staff were expected to complete the PASD assessment quarterly in PCC using the "Alternatives to Restraint / PASD Assessment" form and this was not done.
The home failed to ensure that the plan of care for resident #006 was based on an assessment of the resident, and the needs and preferences of the resident.

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

each other.

(A) Resident #002's plan of care, revised in October 2017, stated they were usually continent of bowel, and frequently incontinent of bladder.

Review of coding regarding bowel continence in the resident's November 2017 quarterly Minimum Data Set (MDS) assessment indicated they were occasionally incontinent of bowel; however, documentation completed by PCA during the 14 day look-back period during the MDS assessment revealed the resident was frequently incontinent of bowel. Under the urinary continence Resident Assessment Protocol (RAP), completed by registered nursing staff it stated the resident was usually continent of bowel. At the time of the inspection, a 14 day look-back of current PCA documentation also indicated the resident was frequently incontinent of bowel.

Review of coding regarding bladder continence in the resident's November 2017 quarterly MDS assessment indicated they were frequently incontinent of bladder; however, documentation completed by PCA's during the 14 day look-back period revealed the resident was incontinent of bladder. Under the urinary continence RAP, completed by registered nursing staff it stated the resident was frequently incontinent of bladder. PCA #114 was interviewed and confirmed the resident was incontinent of bladder. At the time of the inspection, a 14 day look-back of current PCA documentation also indicated the resident was incontinent of bladder.

Interview with RPN #102 confirmed the PCA documentation during the review period indicated the resident experienced frequent bowel incontinence and was incontinent of bladder. RPN #102 confirmed the assessments of resident #002's bowel and bladder continence in November 2017, though PCA documentation, coding and RAPs were not integrated, consistent with or complement each other.

(B) Resident #003's plan of care, revised in October 2017, stated they were frequently incontinent of bowels. Under the bladder function section, the plan indicated the resident was incontinent of bladder; however, under the bowel function section, identified the resident was frequently incontinent of bladder.

Review of coding regarding bowel continence in the resident's November 2017 quarterly MDS assessment indicated they were usually continent of bowel; however, documentation completed by PCA during the 14 day look-back during the MDS assessment period revealed the resident was frequently incontinent of bowel. Review of

the urinary continence RAP completed by registered nursing staff stated the resident was usually continent of bowel. At the time of the inspection, a look-back of current PCA documentation indicated the resident experienced frequent bowel incontinence.

Review of coding and PCA documentation for bladder continence in the resident's November 2017 quarterly MDS assessment identified they were incontinent of bladder; however, the RAP identified the resident as frequently incontinent of bladder. At the time of the inspection, a 14 day look-back of current PCA documentation also indicated the resident was incontinent of bladder. PCA #114 and RPN #102 were interviewed and confirmed the resident was incontinent of bladder.

Interview with RPN #102 confirmed the PCA documentation during the November 2017 MDS assessment indicated the resident experienced frequent bowel incontinence; however, the coding and RAP did not match the PCA assessments. RPN #102 reported the resident was incontinent of bladder; however, confirmed the RAP was not consistent with the PCA assessment and coding by registered nursing staff. RPN #102 confirmed the assessments of the resident #003's bowel and bladder continence in November 2017, though PCA documentation, coding and RAPs were not integrated, consistent with or complement each other.

(C) Resident #004's plan of care, revised in October 2017, stated they were continent of bowel, and frequently incontinent of bladder, as confirmed in an interview with RPN #124.

Review of the resident's quarterly MDS assessment completed in October 2017 indicated they were continent of bowel and frequently incontinent of bladder; however, documentation completed by PCAs during the 14 day look-back period during the MDS review period revealed the resident was frequently incontinent of bowel and incontinent of bladder. Review of the urinary continence RAP completed by registered nursing staff stated the resident was continent of bowel and frequently incontinent of bladder. The resident's most recent continence evaluation, completed prior to the MDS assessment indicated the resident was continent of bowels.

PCA #122 and PCA #123 were interviewed and reported the resident experienced bowel incontinence and was incontinent of bladder. RPN #124 was interviewed and confirmed the resident was incontinent of bladder and experienced bowel incontinence for a period of time. RPN #124 verified the resident was coded as continent of bowel and frequently continent of bladder in the October 2017 MDS assessment; however, confirmed the PCA

documentation identified the resident was frequently incontinent of bowel and incontinent of bladder. RPN #124 also confirmed that RAP was not consistent with the PCA documentation; nor was the continence evaluation in 2017. RPN #124 confirmed the assessments of the resident #004's bowel and bladder continence in October 2017, though PCA documentation, coding, RAP and continence evaluation were not integrated, consistent with or complement each other.

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

(A) In January 2017, the home submitted Critical Incident (CI) #2881-001011-17 to the Director, which identified on a specific date and time in January 2017, resident #012 was found unattended and in a position with a device in place. When the resident was found, no injuries were noted.
Review of the resident's plan of care at the time of the incident stated they required two staff assistance for the provision of specific care.
PCA #110 was interviewed and reported to the LTCH Inspector #585 that they assisted resident #012 with a device in the provision of care. PCA #110 confirmed no one else assisted them with the care. PCA #110 stated they remained with the resident for approximately five minutes, left the resident and did not return. PCA #110 was unable to recall why they left the resident unattended and why they did not return; however, reported the resident required two staff assistance for the specific care with a device.
PCA #138 was interviewed and confirmed that during rounds, staff found resident #012 in a position with no staff present. According to PCA #138, the resident was not in distress and no injuries were identified.
Interview with the Kinesiologist who reported when a specific device was used, two staff must be present.
Interview with NC #117 reported at the time of the incident, the resident's plan of care was for two staff to assist with the provision of care. NC #117 confirmed that the care set out in the plan of care related to the provision of care was not implemented as specified in the plan. (585)

(B) Review of resident #018's clinical record identified they had a history of responsive behaviours, which was confirmed in an interview with BSO staff #146. Interventions outlined in the resident's plan of care were identified and directed staff in order to mitigate the resident's responsive behaviours.
As per the home's critical incident in December 2016, the Physiotherapy Assistant (PTA) #150 observed resident #018 exhibiting responsive behaviours toward resident #017.

The report identified the details of what the PTA had observed. PTA#150 removed resident #017 from the situation and resident #017 did not show signs of distress, emotion or awareness to what was going on.
In an interview with PTA #150, they confirmed that they observed resident #018 exhibiting responsive behaviours toward resident #017.
Interview with BSO staff #146 reported resident #018's plan of care provided the interventions for staff to implement; however, confirmed the plan of care was not implemented to respond to resident #018's responsive behaviours.
The CI report also identified that a specific intervention would be implemented for resident #018 immediately following the incident. In an interview with the ADNC, they reported and provided documentation that the intervention was not provided as required on nine specific dates in December 2016.
The home did not provide the care as specified in resident #018's plan of care in order to manage their responsive behaviours. (585)

(C) The clinical record of resident #023 was reviewed including the written plan of care. They indicated the resident required the use of a specific device when utilizing a mobility aid. The staff were required to visually check resident every hour for safety, comfort, positioning and correct any concerns.
The home's records including Critical Incident report #2881-000021-17, and the investigation records were reviewed and it was noted that in November 2017, resident #023 was in their mobility aid. The resident fell and sustained an injury. The resident's device was not applied as per their plan of care.
The Acting Director of Nursing Care (DNC) and the Assistant Director of Nursing Care (ADNC) were interviewed and confirmed that the staff did not apply the resident's device as per their plan of care. (123)

(D) In July 2016, the staff identified that resident #015 had an injury which worsened. The Nurse Practitioner (NP) assessed the resident and ordered a test. The test was not completed until the beginning of August 2016, which was eight business days later. Based on the test, the resident was diagnosed with an injury.
RPN #143 was interviewed and confirmed that the NP ordered the test and the form was expected to be faxed to their service provider. The home would have subsequently received a confirmation of the faxed requisition, then registered staff would document in the progress notes in the resident's clinical record. The RPN indicated that if they had not received a date and time for the test, then the registered staff were expected to follow-up with the service provider within three (3) business days.
The ADNC was interviewed and confirmed that there was a long delay in the resident

getting their test completed and the registered staff were expected to fax the form, staple the confirmation to the form and document in the resident's clinical record confirming the fax information. Then if the test was not done within three days, the registered staff were expected to follow-up with the service provider. The ADNC confirmed that the staff did not follow-up with the service provider as expected.
The home failed to ensure that resident #015's test request was faxed to the service provider as set out in the plan of care, which delayed diagnosis and treatment for the resident.

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

(A) Resident #001 had an area of altered skin integrity. The clinical record was reviewed and based on the plan of care the resident had a change in condition to the area. Upon further review of the written plan of care, there was no indication that the altered skin integrity the resident previously experienced was healed; there was no indication that the resident's mobility needs had changed; there was no indication that the resident was being followed by the Enterostomal Therapy (ET) nurse or another service provider on a regular basis.
RPN #106 was interviewed and identified that the resident was assessed by another service provider; that the ET nurse assessed the resident on a scheduled basis and makes recommendations; and the resident's mobility needs had changed.
The Skin and Wound Care Lead/RPN #115 was interviewed and confirmed the interventions as previously noted for resident #001. They also confirmed that the written plan of care was expected to be revised and updated by the registered staff when the resident's care changed and/or was no longer necessary.
The home failed to review and revise resident #001's written plan of care when the resident's care needs changed and/or when the care set out in the plan was no longer necessary. (527)

(B) In August 2017, resident #012 was transferred from one unit to another unit in the home.
The resident's plan of care was reviewed and identified they required assistance to toilet in the morning, after lunch and before bed. The plan also stated they required a specific level of assistance with transfers. A transfer logo at the resident's bedside also indicated the same level of assistance for transfers in the plan of care.
PCA #134 and PCA #135 who were regular staff were interviewed and reported that from

the time the resident moved to the new unit, they used a different level of assistance for all transfers and did not assist the resident to the toilet. PCA #134 and PCA #135 confirmed the resident's individual care services plan, which was used by PCA's to direct the resident's care needs, did not reflect the form of care they provided the resident. PCA #135 confirmed the bedside logo stated the resident required a different level of care than provided.
RN #139 was interviewed and reported the resident was not toileted. RN #139 stated they were unaware of the level of assistance PCAs typically provided in relation to transfers. RN #139 confirmed the resident had not been reassessed nor had the plan of care been reviewed and revised in regards to their care needs.
The Kinesiologist was interviewed and reported that if staff regularly used a specific level of care for transfers when the resident's plan of care indicated otherwise, the expectation would be for registered staff to submit a referral to the Kinesiologist to reassess the resident. The Kinesiologist reported they had not received a referral to reassess the resident in the last six months and confirmed the resident had not been reassessed nor had the plan of care been reviewed and revised when their care needs changed in relation to safe transfers. (585)

(C) Review of resident #007's plan of care, including the written plan of care, orders, diet list, and dietary assessments completed by the RD stated they were to receive a modified diet and regular fluids.
During lunch meal observation in January 2018, the resident was provided modified textured fluids. PCA #112 and RPN #102 were interviewed and reported the resident received modified fluids. PCA #114 was interviewed and reported staff provided the fluids for approximately six months.
Review of the clinical record revealed that in June 2017, the physician assessed the resident and noted a change in status. No referral was made to the RD when the resident's status changed. Following the resident's change in status, the clinical record revealed they were not assessed by the RD until approximately three months later, at which time they completed a quarterly assessment and noted the resident's diet order as modified texture and regular fluid. Subsequent assessments completed by the RD on specific dates in November and December 2017, continued to specify that the resident was to receive regular fluid.
In January 2018, the RD was interviewed and reported they were unaware staff were providing the resident with modified fluid; nor had they received a referral when the resident was assessed and had a change in status in June 2017. The RD reported that when staff change resident's fluid consistency or a resident's care needs change, the home's expectation was to refer to the RD.

Interview with RPN #102 confirmed that nursing staff trialled the modified fluids in approximately July 2017, as the resident had symptoms and that nursing staff identified the resident tolerated the fluids better; however, confirmed that no referral was made to the RD to assess the resident when the resident's care needs changed, nor was the plan of care reviewed and revised. (585)

Additional Required Actions:

CO # - 001, 002 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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

As per the Long-Term Care Homes Act 2007, Ontario Regulation 79/10, and for the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to subsection (2),
(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident.

(A) The home's records including Critical Incident (CI) #2881-000028-16, were reviewed and it was noted that on a specific date in November 2016, resident #013, who had a history of physically responsive behaviours was observed to demonstrate a behaviour towards resident #014. Resident #014 suffered physical injury as a result of this incident, which required treatment. In addition, the resident required ongoing assessments completed by registered staff.
The clinical records of residents #013 and #014 were reviewed and contained information as contained in the home's records.
The Behavioural Support Ontario (BSO) Lead was interviewed and confirmed that resident #013 physically abused resident #014.
Resident #014 was not protected from physical abuse by resident #013.

(B) The home's records including CI #2881-000001-17, were reviewed and they indicated that on a specific date in December 2016, resident #013 was observed to demonstrate a behaviour towards resident #014. Resident #014 sustained an injury, which required medication as per the home's medical directives. Resident #013 had a history of physical responsive behaviours.
The clinical records of resident #013 were reviewed and contained information as noted in the home's records.
The BSO Lead was interviewed and confirmed that resident #014 was physically abused by resident #013.
The home did not protect resident #014 was from physical abuse by resident #013.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

(A) The licensee failed to ensure that all direct care staff were provided training in falls prevention and management in 2017.

The home's record of the 2017 Falls Prevention and Management Education was reviewed. It was noted that 86 percent of the staff were provided the education. ADOC

was interviewed and confirmed the accuracy of the information in the home's record as above.
The home did not ensure that all direct care staff were provided training in falls prevention and management in 2017. (123)

(B) The licensee failed to ensure that all direct care staff were provided training annually, as required under O. Reg 79/10 s. 221. (1), in the area(s) of: 3. Continence care and bowel management.

Review of the home's 2017 staff education records identified that 83% of direct care staff received training on continence care and bowel management, which was confirmed by the GM. (585)

(C) The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, additional training in accordance with Long Term Care Homes Act 2007, c. 8, s. 76 (7) 2 and 3 and O. Reg. 79/10, s. 219(1) in the areas of mental health issues, including caring for a persons with dementia and behaviour management.

Interview with the ADNC reported that personal expressions (responsive behaviour) education was considered annual mandatory education for staff. Training documents provided by the home confirmed that 85% of staff identified as providing direct care to residents in 2017 received training in the areas mentioned above in the 2017 calendar year. (585)

(D) The licensee failed to ensure that all staff who provided direct care to residents received the training provided for in subsection 76 (7) of the Act based on the following: 1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. 2. If the licensee assessed the individual training needs of a staff member, the staff member was only required to receive training based on their assessed needs.

The home's training records provided to the LTCH Inspector #527 identified that not all staff who provided direct care to residents received the training provided for in subsection 76 (7), related to abuse recognition and prevention. The home's training record indicated that 93% of all staff were trained in abuse recognition and prevention in 2017.
The home's policy called "Prevention of Abuse and Neglect", number 04-06 and revised November 20, 2016, indicated that annually, team members would receive education on

abuse prevention, mandatory reporting and whistle blowing; Residents' Bill of Rights in long term care; team member's role in handling complaints; and personal expressions.
The General Manager (GM) was interviewed and confirmed that not all staff were trained in all areas required in subsection 76 (7) of the Act, specifically related to abuse recognition and prevention and the areas outlined in the home's policy.
The home did not ensure that all staff received the training provided for in subsection 76 (7) of the Act related to abuse recognition and prevention. (527)

(E) The licensee failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following were other areas in which training should be provided to all staff who provide direct care to residents: 2. Skin and wound care.

The home’s policy called “Skin and Wound Care Program”, number 04-78, and effective June 2017, was reviewed and indicated that team members would receive annual education related to skin care and wound management.
RN #100, PCA #106 and #107 were interviewed and confirmed that they received training related to skin and wound care annually and all staff were expected to attend every year.
The GM was interviewed and confirmed that only 83% of direct care staff were trained in 2017 related to the home’s skin and wound care program. (527)

(F) The licensee failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following were other areas in which training should be provided to all staff who provide direct care to residents: 6. For staff who apply PASDs or monitor residents with PASDs, training in the application, and use and potential dangers of the PASDs.

The home’s policy called “Restraint and PASD Procedures in LTC”, number 04-52, and effective June 2017, was reviewed and indicated that team members providing direct care will be retrained annually on PASD policies and procedures as well as the correct use of equipment as it related to their job responsibilities.
RN #126, PCA #125 and PCA #127 were interviewed and confirmed that they received training related to PASDs, but were unable to identify if they were educated on the application of PASDs. The staff also confirmed that they were not aware that they were expected to locate the manufacturer's instructions in order to ensure that a resident's device was applied correctly.
The Neighbourhood Coordinator #127 was interviewed and confirmed that staff were expected to apply the assistive devices according to manufacturer's instructions and they

were expected to check the device for positioning.
The GM was interviewed and confirmed that only 83% of all direct care staff were trained in 2017 related to PASD application, monitoring, usage and potential dangers of PASDs. The home failed to ensure that all staff who apply PASDs or who monitor residents with PASDs were trained in the application, use and potential dangers of PASDs.

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is: complied with.
Ontario Regulation 79/10 section 49 required that all long-term care homes have a falls prevention and management program.

The home's policy called "Fall Prevention and Management (LTC)", number 04-33, was reviewed and it included: Person who discovers or witnesses the fall: Do not move the resident until they have been cleared by a registered team member.
The home's records including Critical Incident #2881-000021-17 and the investigation record were reviewed and it was noted that resident #023 fell and was transferred by a non-registered staff prior to notifying the registered staff.
The Acting DNC and the ADNC were interviewed and confirmed the staff did not follow the home's falls prevention and management policy.

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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with, to be implemented voluntarily.

WN #5: 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 to promote zero tolerance of abuse

and neglect of residents was complied with.

(A) A review of the home's policy called, "Prevention of Abuse and Neglect", number 04-06 and revised November 2016, directed all staff, students and volunteers who witnessed or suspected the abuse of a resident, or received a complaint of abuse, were required to report the matter immediately.
A review of the critical incident report, the home's investigative notes, and the clinical record in relation to the alleged abuse by RPN #108 to resident #015, confirmed that the home became aware of the alleged abuse on a specific date in April 2017; however they did not report the incident immediately. The home had knowledge of the alleged abuse for five days before reporting to the Director.
An interview with the NC #117 confirmed that the home did not submit the critical incident report to the Director immediately; therefore did not comply with the home's abuse policy. The GM was interviewed and also confirmed that they did not report the alleged emotional abuse of resident #015 immediately, as directed in their policy. (527)

(B) The licensee's policy called, "Prevention of Abuse and Neglect", number 04-06, and revised November 2016, indicated that any person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and information upon which it was based to their immediate supervisor or any member of the leadership team, including abuse of a resident by anyone or neglect of a resident by staff that resulted in harm or risk of harm to the resident. The Prevention of Abuse and Neglect policy referenced policy, "Mandatory Reporting - Tab 04-23", that stated that if reporting to the GM or their designate occurs between 8 a.m. and 5 p.m. from Monday to Friday, they will immediately initiate the on-line mandatory Critical Incident System form using the "Mandatory Report" section (MCIS).
Staff did not comply with the above noted direction when on a specific date in December 2016, Physiotherapist Aide (PTA) #150 and PTA #151 observed resident #018 exhibiting responsive behaviours towards resident #017.
Interviews with PTA #150 and PTA #151 revealed they did not immediately report the incident to their manager or charge nurse. The Physiotherapist, who was the PTA's supervisor, was interviewed and reported they were not aware of the incident until lunch time. Interview with resident #017's Neighbourhood Co-ordinator (NC) #141 stated they were not immediately notified of the incident until the afternoon and they were unable to recall who notified them of the incident. The home submitted a Critical Incident Report (CIR) over eight hours after the incident was identified. NC #141 and the CIR confirmed that the Director was not notified until over eight hours after the suspected resident to resident sexual abuse was observed.

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

In January 2017, the home submitted CI #2881-001011-17 to the Director, which identified on a specific date and time in January 2017, resident #012 was found unattended for several hours and in a position with a device in place. When the resident was found, no injuries were noted.
Review of the resident's plan of care at the time of the incident stated they required two staff assistance for the provision of specific care.
PCA #110 was interviewed and reported to LTCH Inspector #585 that they assisted resident #012 with a device in the provision of care. PCA #110 confirmed no one else assisted them with the care. PCA #110 stated they remained with the resident for approximately five minutes, left the resident in the washroom and did not return. PCA #110 was unable to recall why they left the resident unattended and why they did not return; however, reported the resident required two staff assistance for the specific care with a device.
PCA #138 was interviewed and reported to LTCH Inspector #585 that during rounds, staff found resident #012 in a position, with no staff present. According to PCA #138, the resident was not in distress and no injuries were identified.
Interview with the Kinesiologist who reported anytime a specific device was used, two staff must be present. Interview with NC #117 reported at the time of the incident, the resident's plan of care was for two staff to assist with the provision of care. Further, NC #117 confirmed that when a mechanical device was used, two staff must be present. NC #117 confirmed that PCA #110 did not use safe techniques when providing care to resident #012.

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 staff use safe transferring and positioning devices or techniques when assisting residents, 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. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

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 a written record was kept in relation to each evaluation under clause (b) that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that the changes were implemented.

Review of the written record of the home's Personal Expression Program (Responsive Behaviour Program) annual evaluation for 2017 did not include the dates the changes were implemented, which was confirmed in an interview with the DNC and BSO staff #146.

2. The licensee failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions were documented.

Resident #018’s clinical record revealed they had history of multiple responsive behaviours, which was confirmed in an interview with BSO staff #146. In December 2016, an intervention included in the plan of care to respond to the need of the resident included Dementia Observational System (DOS) charting. Review of the clinical record between specific dates in December 2016, revealed DOS charting was incomplete on four days.
BSO staff #146 confirmed in an interview that staff were expected to complete the DOS documentation during the reviewed period; however, confirmed that it was not completed as required.

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, (c) a written record was kept relating to each evaluation under clause (b) that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, and to ensure that, for each resident demonstrating responsive behaviours, and (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented, to be implemented voluntarily.

WN #8: 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 the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions.

The home provided manufacturer's instructions related to an device for resident #023. The instructions included how to apply and test the device.
The clinical record of resident #023 was reviewed and it indicated that the resident required the use of a specific device.
On a specific date in January 2018, the resident was observed utilizing a mobility aid with their device applied. Upon closer observation by the LTCH Inspector #123, it was noted that the device was not applied according to manufacturer instructions. This was confirmed by PSW #152 and registered staff #102. They reported that the device should be applied as instructed, and adjusted to fit as per manufacturer's instructions.
The staff did not apply the resident's device according to manufacturer's instructions.

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 following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #9: 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, (b) was applied by staff in accordance with any manufacturer's instructions.

Resident #006 was observed on three specific dates in January 2018, with an assistive device applied. The resident was interviewed and said that they were comfortable with the device and that there were times that the device was not in the correct position. They said it fluctuated as to the positioning and tightness of the device.
The plan of care was reviewed, which confirmed the resident had a specific assistive device applied while utilizing their mobility aid. The assistive device was identified in the plan of care as a Personal Assistance Services Device (PASD).
The home's policy called "Restraint and PASD Procedures in LTC", number 04-52, and effective June 2017, directed staff to apply physical devices according to the manufacturer's specifications. The policy also directed staff to include in the resident's plan of care the type of device and specific steps for applying and reapplying the device.
RN #126 was interviewed and confirmed the resident had a specific assistive device in place. The RN indicated the device was considered a PASD as it assisted the resident with activities of daily living, and was only applied when the resident was utilizing their mobility device. The RN was unable to identify in the plan of care, the instructions for the application of the device and was unable to locate the manufacturer instructions.
PCA #125 was interviewed identified the resident had a device, which was a PASD, but they were not aware of any specific instructions or manufacturer specifications for the application of the device. The PCA stated that to apply the resident's device was "common sense".
The Neighbourhood Coordinator (NC) #127 was interviewed and confirmed that staff were expected to include any specific instructions in the plan of care related to the application of the resident's specific device, and they were expected to follow the manufacturer's specifications. The NC was unable to locate the manufacturer's specifications for resident #006's device.
The home failed to ensure that the manufacturer's instructions were used in the application of the resident #006's assistive device.

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, (b) was applied by staff in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 127. Every licensee of a long-term care home shall ensure that a policy is developed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director, to govern changes in the administration of a drug due to modifications of directions for use made by a prescriber, including temporary discontinuation. O. Reg. 79/10, s. 127.

Findings/Faits saillants :

1. The licensee failed to ensure that a policy was developed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director, to govern changes in the administration of a drug due to modifications of directions for use made by a prescriber, including temporary discontinuation.

Resident #021 was ordered by the physician on a specific date in December 2016, to hold a specific medication for seven (7) days. The physician's order was transcribed by RPN #143 and double-checked by RPN #145.
The resident's clinical record, the investigative notes related to the medication incident and adverse drug reaction, and the hospital notes were reviewed.
The Medication Administration Record (MAR) had the medication hold documented for the seven days; however there was no documentation in the clinical record that the physician needed to be called to reassess the resident's medication requirements after the seven days. The home was unable to provide any policy, protocol or guideline as to what was expected of the registered staff when a medication was on hold and what actions needed to be taken thereafter.
The MAR was signed by registered staff on specific dates in December 2016 and January 2017, which indicated that the medication that was originally on hold, was administered; however during an interview with the DNC, the ADNC and RPN #143, they confirmed that the staff had not administered the medication and they also had none of the specific medication for this resident in their medication drawer to administer.
The physician re-ordered on a specific date in January 2017, to discontinue the specific medication, which the power of attorney agreed. Approximately one week later, resident #021 was transferred to the hospital for further assessment.
The hospital notes were reviewed and indicated that the resident's original assessment revealed no abnormalities, but on examination the resident had specific symptoms. The hospital physician discharged the resident back to the home with a prescription. When the resident returned to the home, the physician re-ordered the specific medication for two weeks then re-assess. The resident had no further clinical issues.
The home failed to ensure that a policy was developed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director, to govern changes in the administration of the specific medication for resident #021, as a result of the modifications of directions for use made by the physician, including temporary discontinuation of the medication, which resulted in the resident's adverse reaction.

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 policy was developed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director, to govern changes in the administration of a drug due to modifications of directions for use made by a prescriber, including temporary discontinuation, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

(A) The critical incident report submitted to the Director in April 2017, indicated that there was an allegation of staff to resident emotional abuse by RPN #108 towards resident #015.
A review of the home's policy called, "Investigation Process for Suspected Abuse of a Resident by Team Member, Volunteer or Visitor", number 04-06B, and effective December 2016, directed staff that upon completion of the investigation the GM or designate leadership team member would update the critical incident report.
The critical incident report and the home's investigative notes were reviewed by LTCH Inspector #527, which revealed that there were no results of the investigation related to the alleged staff to resident emotional abuse reported to the Director.
The Neighbourhood Coordinator (NC) #117 was interviewed and confirmed that they did not amend the critical incident report with the results of their investigation and did not submit this information to the Director.
The General Manager (GM) was interviewed and confirmed that the results of the investigation were not reported to the Director after the investigation was completed.

(B) The critical incident report submitted to the Director in September 2016, indicated that there was an allegation of staff to resident emotional abuse by PCA #149 towards resident #020.
The critical incident report and the home's investigative notes were reviewed by LTCH Inspector #527, which revealed that there were no results of the investigation related to the alleged staff to resident emotional abuse reported to the Director.
The Neighbourhood Coordinator (NC) #117 was interviewed and confirmed that they did not amend the critical incident report with the results of their investigation and did not submit this information to the Director.
The General Manager (GM) was interviewed and confirmed that the results of the investigation was not reported to the Director after the investigation was completed.

The home failed to ensure that the results related to the home's investigation undertaken related to the alleged emotional abuse of resident #015 and #020 was reported to the Director.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The home's 2017 annual evaluation of the fall prevention and management program was reviewed and it did not include the date the changes were implemented. This was confirmed with the Acting DNC.
The home's evaluation of the falls prevention and management program did not include the dates the changes were implemented.

WN #13: 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 a resident with a routine activity of living may be included in a resident's plan of care only if all of the following were 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.

Resident #006 was observed on three specific dates in January 2018, with an assistive device applied while utilizing a mobility aid.
The home's policy called "Restraint and PASD Procedures in LTC", number 04-52, and effective June 2017, directed staff to ensure that all of the criteria were met before the use of a PASD on a resident. This included that alternatives be considered and tried where appropriate, but were deemed ineffective.
The plan of care was reviewed and the LTCH Inspector #527, who was unable to identify if any alternatives were considered prior to use of the PASD.
Resident #006 was interviewed on a specific date in January 2018, they were not aware of any alternatives ever being considered rather than the specific device they currently had in place.
RN #126 was interviewed and was not aware of any alternatives being considered prior to the use of the specific device for resident #006. The RN was unable to find any alternatives to the PASD documented on the written plan of care.
Neighbourhood Coordinator #127 was interviewed and confirmed that staff were expected to consider alternatives prior to the implementation of the PASD and was not aware of the alternatives that may or may not have been attempted for resident #006.
The home failed to ensure that alternatives to the use of the PASD for resident #006 were considered, and tried if appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.

Issued on this 26th day of February, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KATHLEEN MILLAR (527), LEAH CURLE (585), MELODY GRAY (123)
Inspection No. / No de l'inspection :	2018_544527_0001
Log No. / No de registre :	006294-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 22, 2018
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village of Erin Meadows 2930 Erin Centre Boulevard, MISSISSAUGA, ON, L5M-7M4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Ash Agarwal

To Schlegel Villages Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall complete the following:

1) Ensure there is a written plan of care for resident #023, that sets out the planned care for the resident, including all safety needs.

2) Educate direct care staff that are involved in the provision of care on the home's policies and procedures related to the written plan of care for each resident and that it sets out, the planned care for the residents.

3) Develop and implement an auditing process to improve and ensure compliance with the written plans of care, including all of the planned care for the residents.

Grounds / Motifs :

1. This Order was made based upon the application of the factors of severity (3), scope (1) and compliance history (4), in keeping with s.299(1) of the Regulation. There was actual harm to resident #023, the scope was isolated, and the Licensee's history of non-compliance (VPC) on December 20 and January 20, 2016 Resident Quality Inspections related to s. 6 (1)(a).

2. The licensee failed to ensure that there was a written plan of care for each resident that set out, the planned care for the resident.

The clinical record of resident #023 was reviewed including the written plan of care and progress notes. They indicated that during the provision of care on a specific date in November 2017, the resident had a fall. The resident suffered injury during the specific care. Review of the resident's clinical record indicated that during the specific care, staff were to ensure that the resident was positioned correctly. The interventions related to proper positioning of the resident during the care was not included in the written plan of care.
The home's records were reviewed including Critical Incident (CI) #2881-000021-17 and the investigation records and they included information as above.
Personal Care Aide (PCA) #152, Registered Practical Nurse (RPN) #102 and the Physiotherapist (PT) were interviewed. They confirmed that the resident required specific positioning during the provision of the identified care.
The PT reviewed the written plan of care and confirmed that the information related to the resident's need for proper positioning during the specific care was not included in their care plan.
(123)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 30, 2018

Order # / Ordre no : 002

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

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 complete the following:

1) Ensure the care set out in the plan of care is provided to resident #012, #015, #018 and #023 as specified in the plan.

2) Educate all direct care providers that are involved in the provision of care on the home's policies and procedures related to the use of the plan of care, how to the plan of care of care is revised and ensuring the care set out in the plan is provided to each resident as specified in their plan.

3) Develop and implement an auditing process to improve and ensure compliance with following the plan of care.

Grounds / Motifs :

1. This Order was made based upon the application of the factors of severity (3), scope (2) and compliance history (4), in keeping with s.299(1) of the Regulation. There was harm to residents, the scope was a pattern, and the Licensee's history of non-compliance of WN and VPC as a result of the January 20, 2016 Resident Quality Inspection.

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

(A) In January 2017, the home submitted Critical Incident (CI) #2881-001011-17 to the Director, which identified on a specific date and time in January 2017, resident #012 was found unattended and in a position with a device in place. When the resident was found, no injuries were noted.

Review of the resident's plan of care at the time of the incident stated they required two staff assistance for the provision of specific care.
PCA #110 was interviewed and reported to the LTCH Inspector #585 that they assisted resident #012 with a device in the provision of care. PCA #110 confirmed no one else assisted them with the care. PCA #110 stated they remained with the resident for approximately five minutes, left the resident and did not return. PCA #110 was unable to recall why they left the resident unattended and why they did not return; however, reported the resident required two staff assistance for the specific care with a device.
PCA #138 was interviewed and confirmed that during rounds, staff found resident #012 in a position with no staff present. According to PCA #138, the resident was not in distress and no injuries were identified.
Interview with the Kinesiologist who reported when a specific device was used, two staff must be present.
Interview with NC #117 reported at the time of the incident, the resident's plan of care was for two staff to assist with the provision of care. NC #117 confirmed that the care set out in the plan of care related to the provision of care was not implemented as specified in the plan. (585)

(B) Review of resident #018's clinical record identified they had a history of responsive behaviours, which was confirmed in an interview with BSO staff #146. Interventions outlined in the resident's plan of care were identified and directed staff in order to mitigate the resident's responsive behaviours.
As per the home's critical incident in December 2016, the Physiotherapy Assistant (PTA) #150 observed resident #018 exhibiting responsive behaviours toward resident #017.
The report identified the details of what the PTA had observed. PTA #150 removed resident #017 from the situation and resident #017 did not show signs of distress, emotion or awareness to what was going on.
In an interview with PTA #150, they confirmed that they observed resident #018 exhibiting responsive behaviours toward resident #017.
Interview with BSO staff #146 reported resident #018's plan of care provided the interventions for staff to implement; however, confirmed the plan of care was not implemented to respond to resident #018's responsive behaviours.
The CI report also identified that a specific intervention would be implemented for resident #018 immediately following the incident. In an interview with the ADNC, they reported and provided documentation that the intervention was not provided as required on nine specific dates in December 2016.
The home did not provide the care as specified in resident #018's plan of care in

order to manage their responsive behaviours. (585)

(C) The clinical record of resident #023 was reviewed including the written plan of care. They indicated the resident required the use of a specific device when utilizing a mobility aid. The staff were required to visually check resident every hour for safety, comfort, positioning and correct any concerns.
The home's records including Critical Incident report #2881-000021-17, and the investigation records were reviewed and it was noted that in November 2017, resident #023 was in their mobility aid. The resident fell and sustained an injury. The resident's device was not applied as per their plan of care.
The Acting Director of Nursing Care (DNC) and the Assistant Director of Nursing Care (ADNC) were interviewed and confirmed that the staff did not apply the resident's device as per their plan of care. (123)

(D) In July 2016, the staff identified that resident #015 had an injury which worsened. The Nurse Practitioner (NP) assessed the resident and ordered a test. The test was not completed until the beginning of August 2016, which was eight business days later. Based on the test, the resident was diagnosed with an injury.
RPN #143 was interviewed and confirmed that the NP ordered the test and the form was expected to be faxed to their service provider. The home would have subsequently received a confirmation of the faxed requisition, then registered staff would document in the progress notes in the resident's clinical record. The RPN indicated that if they had not received a date and time for the test, then the registered staff were expected to follow-up with the service provider within three (3) business days.
The ADNC was interviewed and confirmed that there was a long delay in the resident getting their test completed and the registered staff were expected to fax the form, staple the confirmation to the form and document in the resident's clinical record confirming the fax information. Then if the test was not done within three days, the registered staff were expected to follow-up with the service provider. The ADNC confirmed that the staff did not follow-up with the service provider as expected.
The home failed to ensure that resident #015's test request was faxed to the service provider as set out in the plan of care, which delayed diagnosis and treatment for the resident.
(123)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 30, 2018

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall complete the following:

1) Ensure resident #014 is protected from physical abuse by anyone.

2) Ensure that interventions are developed, implemented and evaluated to manage resident #013's responsive behaviours.

3) Develop and implement an auditing process to ensure that residents who exhibit responsive behaviours are re-assessed, new interventions initiated and the plan of care revised.

4) Provide all staff with retraining on the home's prevention of abuse policy and legislation that promotes zero tolerance of abuse and neglect of all residents by anyone.

Grounds / Motifs :

1. This Order was made based upon the application of the factors of severity (3), scope (1) and compliance history (4), in keeping with s.299(1) of the Regulation, in respect to the actual harm that resident #014 experienced, the scope of two incidents, and the Licensee's history of non-compliance (VPC) on January 20, 2016, issued as a result of Resident Quality Inspection.

2. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

As per the Long-Term Care Homes Act 2007, Ontario Regulation 79/10, and for the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical

abuse" means, subject to subsection (2),
(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident.

(A) The home's records including Critical Incident (CI) #2881-000028-16, were reviewed and it was noted that on a specific date in November 2016, resident #013, who had a history of physically responsive behaviours was observed to demonstrate a behaviour towards resident #014. Resident #014 suffered physical injury as a result of this incident, which required treatment. In addition, the resident required ongoing assessments completed by registered staff.
The clinical records of residents #013 and #014 were reviewed and contained information as contained in the home's records.
The Behavioural Support Ontario (BSO) Lead was interviewed and confirmed that resident #013 physically abused resident #014.
Resident #014 was not protected from physical abuse by resident #013.

(B) The home's records including CI #2881-000001-17, were reviewed and they indicated that on a specific date in December 2016, resident #013 was observed to demonstrate a behaviour towards resident #014. Resident #014 sustained an injury, which required medication as per the home's medical directives. Resident #013 had a history of physical responsive behaviours.
The clinical records of resident #013 were reviewed and contained information as noted in the home's records.
The BSO Lead was interviewed and confirmed that resident #014 was physically abused by resident #013.
The home did not protect resident #014 was from physical abuse by resident #013. (123)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 30, 2018

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Order / Ordre :

The licensee shall complete the following:

1) Provide training for direct care providers related to falls prevention and management; continence care; restraints and personal assistive services devices (PASD); skin and wound care; abuse recognition and prevention; and in the areas of mental health issues, including caring for a person(s) with dementia and behaviour management.

2) Maintain all records of the above noted training and participants.

Grounds / Motifs :

1. This Order was based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. The non-compliance was issued as an order due to a severity level of 2 (minimal harm or potential for actual harm); scope of 3 (widespread) and a compliance history of 3 (previous WN, similar area).

2. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents,

training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 1. Abuse recognition and prevention. 2. Mental health issues, including caring for persons with dementia. 3. Behaviour management. 4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 5. Palliative care. 6. Any other areas provided for in the regulations.

(A) The licensee failed to ensure that all direct care staff were provided training in falls prevention and management in 2017.

The home's record of the 2017 Falls Prevention and Management Education was reviewed. It was noted that 86 percent of the staff were provided the education. ADOC was interviewed and confirmed the accuracy of the information in the home's record as above.
The home did not ensure that all direct care staff were provided training in falls prevention and management in 2017. (123)

(B) The licensee failed to ensure that all direct care staff were provided training annually, as required under O. Reg 79/10 s. 221. (1), in the area(s) of: 3. Continence care and bowel management.

Review of the home's 2017 staff education records identified that 83% of direct care staff received training on continence care and bowel management, which was confirmed by the GM. (585)

(C) The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, additional training in accordance with Long Term Care Homes Act 2007, c. 8, s. 76 (7) 2 and 3 and O.
Reg. 79/10, s. 219(1) in the areas of mental health issues, including caring for a persons with dementia and behaviour management.

Interview with the ADNC reported that personal expressions (responsive behaviour) education was considered annual mandatory education for staff. Training documents provided by the home confirmed that 85% of staff identified as providing direct care to residents in 2017 received training in the areas mentioned above in the 2017 calendar year. (585)

(D) The licensee failed to ensure that all staff who provided direct care to

residents received the training provided for in subsection 76 (7) of the Act based on the following: 1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. 2. If the licensee assessed the individual training needs of a staff member, the staff member was only required to receive training based on their assessed needs.

The home's training records provided to the LTCH Inspector #527 identified that not all staff who provided direct care to residents received the training provided for in subsection 76 (7), related to abuse recognition and prevention. The home's training record indicated that 93% of all staff were trained in abuse recognition and prevention in 2017.
The home's policy called "Prevention of Abuse and Neglect", number 04-06 and revised November 20, 2016, indicated that annually, team members would receive education on abuse prevention, mandatory reporting and whistle blowing; Residents' Bill of Rights in long term care; team member's role in handling complaints; and personal expressions.
The General Manager (GM) was interviewed and confirmed that not all staff were trained in all areas required in subsection 76 (7) of the Act, specifically related to abuse recognition and prevention and the areas outlined in the home's policy.
The home did not ensure that all staff received the training provided for in subsection 76 (7) of the Act related to abuse recognition and prevention. (527)

(E) The licensee failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following were other areas in which training should be provided to all staff who provide direct care to residents: 2. Skin and wound care.

The home's policy called "Skin and Wound Care Program", number 04-78, and effective June 2017, was reviewed and indicated that team members would receive annual education related to skin care and wound management.
RN #100, PCA #106 and #107 were interviewed and confirmed that they received training related to skin and wound care annually and all staff were expected to attend every year.
The GM was interviewed and confirmed that only 83% of direct care staff were trained in 2017 related to the home's skin and wound care program. (527)

(F) The licensee failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following were other areas in which training

should be provided to all staff who provide direct care to residents: 6. For staff who apply PASDs or monitor residents with PASDs, training in the application, and use and potential dangers of the PASDs.

The home's policy called "Restraint and PASD Procedures in LTC", number 04-52, and effective June 2017, was reviewed and indicated that team members providing direct care will be retrained annually on PASD policies and procedures as well as the correct use of equipment as it related to their job responsibilities.
RN #126, PCA #125 and PCA #127 were interviewed and confirmed that they received training related to PASDs, but were unable to identify if they were educated on the application of PASDs. The staff also confirmed that they were not aware that they were expected to locate the manufacturer's instructions in order to ensure that a resident's device was applied correctly.
The Neighbourhood Coordinator #127 was interviewed and confirmed that staff were expected to apply the assistive devices according to manufacturer's instructions and they were expected to check the device for positioning.
The GM was interviewed and confirmed that only 83% of all direct care staff were trained in 2017 related to PASD application, monitoring, usage and potential dangers of PASDs.
The home failed to ensure that all staff who apply PASDs or who monitor residents with PASDs were trained in the application, use and potential dangers of PASDs. (527)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 30, 2018

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, commercial courier or by fax upon:

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22nd day of February, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Kathleen Millar

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