Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 8, 2013	2013_220111_0015	000514, 002415, 000812	Critical Incident System

Licensee/Titulaire de permis

THE WEXFORD RESIDENCE INC.
1860 Lawrence Avenue East, TORONTO, ON, M1R-5B1

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

THE WEXFORD
1860 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1R-5B1

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 29, 30, 31, August 12, 26, 27, 28, 29, , September 5, 2013

3 Critical incident inspections were completed.
Additional non-compliance for log # 002415 under LTCHA 2007, s.6 and O.Reg. 79/10 s. 53 is identified as a Compliance Order under inspection #2013_220111_0016 which was completed concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care (DOC),Administrative Assistant, Director of Finance (DOF), Accountant, 2 Nurse Managers (NM), 3 Registered Nurses, 1 Registered Practical Nurse (RPN), 1 Personal Support Worker (PSW), and the Pharmacy Consultant.

During the course of the inspection, the inspector(s) observation of 5 residents, reviewed financial records for 3 residents, reviewed health record for 5 residents, reviewed the homes investigation into 2 incidents of missing narcotics, reviewed nursing staff schedules, reviewed the homes policy on Narcotics/Controlled drugs, Wandering Policy, Resident Armbands and the homes Admission Agreement package.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Medication

Resident Charges

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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 O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following:

s. 241. (8) A resident, or a person acting on behalf of a resident, who wishes to pay a licensee for charges under section 91 of the Act with money from a trust account shall provide the licensee with a written authorization that specifies what the charge is for, including a description of the goods or services provided, the frequency and timing of the withdrawal and the amount of the charge. O. Reg. 79/10, s. 241 (8).

Findings/Faits saillants :

1. Related to log # 002415:

Review of the trust agreement for Resident #4 indicated the trust account may be used for haircare and foot care. There was no indication of the frequency and timing, or the amount of the charge to be used for each service.

Review of the trust agreement for Resident #5 indicated the trust account may be used for hair care and foot care. There was no indication of the frequency and timing, or the amount of the charge to be used for each service.

Interview of the Director of Finance indicated there were approximately 90 residents with Trust Account agreements in place. The scope of harm and risk of harm is high as the residents with trust accounts in use do not have agreements that include the frequency and timing, or the amount of the charge to be used for each service. The severity is considered widespread as 90 out 166 residents have trust accounts in use.

The licensee failed to ensure that a resident, or a person acting on behalf of a resident, who wishes to pay a licensee for charges with money from a trust account, has provided a written authorization that specifies what the charge is for, including a description of the goods and services provided, the frequency and timing of the withdrawal and the amount of the charge. [s. 241. (8)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (4) A licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf. 2007, c. 8, s. 91. (4).

Findings/Faits saillants :

1. Related to log # 002415:

Review of the progress notes for Resident #2 indicated the Power of Attorney (POA) was contacted for payment for a new wander guard bracelet.

Review of the list of residents with wander guards in place indicated:
-there were 16 resident's currently with wander guards in use
-7 of those resident's received the wander guard in 2013.

Interview of the Director of Finance(DOF) indicated that charges for wander guard bracelets started as of January 1, 2013, Resident #2 was not charged, and only 2 residents (Resident #4 & #5) were actually charged for a wander guard bracelet in 2013. The DOF indicated both Resident #4 & #5 have since been reimbursed for the wander guard.The DOF also indicated the home has always charged ($15.00) to all residents for the ID bracelets. The DOF indicated the home is now in the process of reimbursing all residents past and present who were charged($15.00)for ID bracelets as a result of the inspection.

Review of Resident #2, #4, #5 admission agreements indicated under "Schedule B":
-a charge of ($15.00) for ID bracelet and wander guard ($135.00).
-a wander guard consent was also signed for Resident #4 & #5 for $140.00.

Review of the accommodation account summary and trust account summary for 2013 indicated Resident #2, #4 & #5 had a charge of $15.00 for ID bracelets. There was no indication of a deposit/withdraw for $140.00 for a wander guard bracelet for Resident #4 & #5.

Interview of the Accountant indicated that monies received (from Resident #4 & #5) for payment of wander guards($140.00) were deposited directly into the home's bank account.

The severity of the harm and risk of harm to residents arising from non-compliance was very high. All residents were charged for ID bracelets and 2 residents were charged for wander guard bracelets. The scope of the harm and risk of harm arising from non-compliance is widespread as all residents were charged for ID bracelets as identified in the inspection report.

The licensee failed to ensure that residents were not charged for anything that the regulations provide is not to be charged for. [s. 91. (4)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

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Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,

ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. A Compliance Order was issued for s. 107 under O.Reg. 79/10 during inspection # 2013_220111_0016.

Related to log # 000514:
A Critical Incident report (CI)was received for an incident of a missing narcotic six days after the incident occurred. Interview of the DOC indicated the Director was not notified until the CI was submitted.

The licensee failed to ensure the Director was informed of the incident of missing narcotics no later than one business day after the occurrence. [s. 107. (3)]

2. Related to log # 000812:

A CI was received for 2 missing narcotic incidents that occurred. The CI indicated the first incident involved Resident #1 and occurred 2 days before the CI was submitted. The second incident involved Resident #3 and occurred the day before the CI was submitted.

Review of the homes investigation and review of narcotic records for Resident #1 & #3 indicated there were three separate incidents of missing narcotics. The first incident involved Resident #1 which occurred eight days before the CI was submitted to the Director. The second incident involved Resident #1 again and was discovered two days before the CI was submitted to the Director. The third incident involved Resident #3 and was discovered the day before the CI was submitted to the Director.

The licensee failed to ensure the Director was informed of the incidents of missing narcotics no later than one business day after the occurrence. [s. 107. (3)]

3. Related to log # 000514:

A CI was received for a missing narcotic incident involving Resident #1.

Review of the homes investigation, clinical documentation, and narcotic sheets for Resident #1 indicated that there were actually 3 narcotics unaccounted for [s.107(4)1].

Review of the homes investigation indicated that RN (#101) was directly involved in the missing narcotics incident but the CI did not indicate this staff member[s.107(4)2].

Review of the progress notes and pain assessments for Resident #1 indicated the resident was not assessed for pain despite not receiving narcotic analgesic for a period of 12 days [s.107(4)3.i].

The CI indicated the Substitute Decision Maker (SDM) was not notified of the incident and interview of the DOC confirmed the SDM was not notified[s.107(4)3.iv].

Interview of DOC, Nurse Managers, Pharmacy and review of staff records, indicated there was no documented evidence the short term and long term actions to prevent a recurrence that were indicated on the CI were actually implemented[s.107(4)4.i,ii].

4. Related to log #000812:

A CI was submitted for 2 separate missing narcotic incidents that occurred involving Resident #1 and Resident #3 that occurred 2 days before the CI was submitted.

Review of the homes investigation and review of narcotic records indicated there was actually 3 separate incidents of missing narcotics. The first incident involved 4 narcotics unaccounted for Resident #1 that occurred 8 days before the CI was submitted. The second incident had 1 missing narcotic for Resident #1 that occurred the day before the CI was submitted. The third incident involved a missing narcotic for Resident #3 that was discovered the day the CI was submitted[s.107(4)1].

The CI indicated Resident #1 & #3 SDM's were not contacted.Interview of the DOC confirmed the SDM's were not contacted[s.107(4)3.iv].

The CI indicated the short term actions included pain assessments for Resident #1 & #3, notification of Police, Physician and Pharmacy. The long term actions included disciplinary action and notification of the College of Nurses (CON).

Interview of the DOC indicated additional short term actions taken to prevent a recurrence included ongoing monitoring of the staff member involved in the incidents of missing narcotics.
Interview of the staff confirmed the ongoing monitoring did not occur and there were no other actions taken to prevent a recurrence.

The long term actions to prevent a recurrence were actually the immediate actions taken by the home and no other interventions were put in place to prevent recurrence [s.107(4)4.ii].

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is notified of missing or unaccounted for controlled substances no later than one business day, that actions are taken in response to such incidents, immediate and long term actions are taken to prevent recurrence, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Related to log #000514:

Review of physician orders for Resident #1 indicated the resident was to receive the narcotic analgesic every three days.

Review of the Medication Administration Records (MARS) for Resident #1 indicated the narcotic analgesic was not received for a period of 13 days[s.131(2)].

2. Related to log #000812:

Review of health record for Resident #1 indicated a topical narcotic analgesic was discontinued and then re-ordered by RN (#101) without a physician's order.

Review of the narcotic records for Resident #1 indicated:
-the home was unable to locate the individual and shift narcotic count records for the period of time when the narcotic was re-ordered by RN (#101).
-the individual narcotic sheet indicated 5 narcotics were received as a result of the new order [that was transcribed by RN (#101)].
-there was no indication Resident #1 ever received any of the 5 narcotics as ordered and the narcotics were unaccounted for.
-another missing narcotic incident for Resident #1 occurred at a later date again involving RN (#101).

Review of the health record for resident #3 indicated a narcotic analgesic was ordered subcutaneously every 2 hours as needed.

-Review of the "Individual Narcotic Sheet" indicated the home received 10 vials of the narcotic and no indication the resident received any of the narcotic analgesic.
-Review of the homes investigation and narcotic records for Resident #3 indicated the home received 10 vials of the narcotic and no indication the resident received any of the narcotic analgesic. The home noted 1 missing vial of narcotic.

The licensee failed to ensure that drugs were administered to resident #1 & #3 in accordance with the directions for use specified by the prescriber [s. 131(2)].

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all drugs are administered to resident's in accordance with the directions for use as specified by the prescriber, to be implemented voluntarily.

WN #5: 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. (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. Related to log #002415:

Review of the progress notes for Resident #2 indicated the resident had incidents of verbal and physical aggression towards staff and other residents, refused personal care/medications and the use of a wander guard bracelet was not in place for a period of 3 months. Interventions utilized included a yellow wander guard strip at residents door, monitoring residents whereabouts, keeping the resident out of restricted areas, and referral to POP team.

Review of the plan of care for Resident #2 indicated the resident demonstrated responsive behaviours of refusing personal care, exit-seeking, hallucinating and verbal/physical aggression. Interventions included staff to ensure resident wearing "Wander Guard Bracelet" every shift.

There was no indication whom the verbal/physical aggression was directed towards, the use of a yellow wander guard strip on the resident's door, keeping the resident out of restricted areas, how staff would "monitor whereabouts" and use of referrals to specialized psychiatric services.

Observation of the resident indicated there was no wander guard bracelet in place as indicated on the plan and no indication of the use of a yellow strip across the resident's door.

The licensee failed to ensure when the resident was reassessed, the plan of care was reviewed and revised when the resident's care needs changed or when the care set out in the plan was no longer necessary or effective[s.6(10)(b)(c)].

LTCHA, 2007, s.6 was issued as a Compliance Order on May 22, 2013 under LTCHA, 2007, s.19 during inspection #2013_220111_0006 [s.6(10)(b)].

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Related to log #002415:

Review of the progress notes for Resident #2 indicated the resident had incidents of verbal and physical aggression towards staff and other residents, refused personal care/medications and the use of a wander guard bracelet was not in place for a period of 3 months. Interventions utilized included a yellow wander guard strip at residents door, monitoring residents whereabouts, keeping the resident out of restricted areas, and referral to specialized psychiatric services.

Review of the plan of care for Resident #2 indicated the resident demonstrated responsive behaviours of refusing personal care, exit-seeking, hallucinating and verbal/physical aggression. Interventions included staff to ensure resident wearing "Wander Guard Bracelet" every shift.

The known triggers of Resident #2 that resulted in verbal/physical aggressive behaviour towards other resident's were not identified in the plan of care.

The licensee failed to ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible [s.53(4)(a)].

O.Reg.79/10, s.53 was issued as a Compliance Order under LTHCA, 2007, s.19 on May 22, 2013 under inspection # 2013_220111_0006. [s. 53. (4) (a)]

Issued on this 21st day of October, 2013

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

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2013_220111_0015
Log No. / Registre no:	000514, 002415, 000812
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 8, 2013
Licensee / Titulaire de permis :	THE WEXFORD RESIDENCE INC. 1860 Lawrence Avenue East, TORONTO, ON, M1R-5B1
LTC Home / Foyer de SLD :	THE WEXFORD 1860 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1R-5B1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SANDY BASSETT

To THE WEXFORD RESIDENCE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 241. (8) A resident, or a person acting on behalf of a resident, who wishes to pay a licensee for charges under section 91 of the Act with money from a trust account shall provide the licensee with a written authorization that specifies what the charge is for, including a description of the goods or services provided, the frequency and timing of the withdrawal and the amount of the charge. O. Reg. 79/10, s. 241 (8).

Order / Ordre :

The home shall review and revise all resident trust account agreements currently in place in the home to ensure:
- the money used from the trust account includes authorization that specifies what the charge is for,
- including a description of the goods and services provided,
-the frequency and timing of the withdrawal and the amount of the charge.

Grounds / Motifs :

1. 1. Related to log # 002415:

Review of the trust agreement for Resident #4 indicated the trust account may be used for haircare and foot care. There was no indication of the frequency and timing, or the amount of the charge to be used for each service.

Review of the trust agreement for Resident #5 indicated the trust account may be used for hair care and foot care. There was no indication of the frequency and timing, or the amount of the charge to be used for each service.

Interview of the Director of Finance indicated there were approximately 90 residents with Trust Account agreements in place. The scope of harm and risk of harm is high as the residents with trust accounts in use do not have agreements that include the frequency and timing, or the amount of the charge to be used for each service. The severity is considered widespread as 90 out 166 residents have trust accounts in use.

The licensee failed to ensure that a resident, or a person acting on behalf of a resident, who wishes to pay a licensee for charges with money from a trust account, has provided a written authorization that specifies what the charge is for, including a description of the goods and services provided, the frequency and timing of the withdrawal and the amount of the charge. [s. 241. (8)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 07, 2013

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 91. (4) A licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf. 2007, c. 8, s. 91. (4).

Order / Ordre :

1.The licensee shall not charge residents for anything that the licensee is prohibited from charging, (including ID bracelets and wander guard bracelets), and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf.
2. The licensee is to ensure all residents charged for anything prohibited from being charged (including ID bracelets and wander guard bracelets) is reimbursed.
3.The licensee shall review and revise all current and future admission agreements to reflect that the licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging (including ID bracelets and wander guard bracelets).

The plan is to be submitted to Lynda Brown by October 15, 2013 via email at Lynda.Brown2@ontario.ca. The date for complying with 1 & 2 is immediate. The date for complying with 3 is November 7, 2013.

Grounds / Motifs :

1. 1. Related to log # 002415:

Review of the progress notes for Resident #2 indicated the Power of Attorney (POA) was contacted for payment for a new wander guard bracelet.

Review of the list of residents with wander guards in place indicated:
-there were 16 resident's currently with wander guards in use

-7 of those resident's received the wander guard in 2013.

Interview of the Director of Finance(DOF) indicated that charges for wander guard bracelets started as of January 1, 2013, Resident #2 was not charged, and only 2 residents (Resident #4 & #5) were actually charged for a wander guard bracelet in 2013. The DOF indicated both Resident #4 & #5 have since been reimbursed for the wander guard.The DOF also indicated the home has always charged ($15.00) to all residents for the ID bracelets. The DOF indicated the home is now in the process of reimbursing all residents past and present who were charged($15.00)for ID bracelets as a result of the inspection.

Review of Resident #2, #4, #5 admission agreements indicated under "Schedule B":
-a charge of ($15.00) for ID bracelet and wander guard ($135.00).
-a wander guard consent was also signed for Resident #4 & #5 for $140.00.

Review of the accommodation account summary and trust account summary for 2013 indicated Resident #2, #4 & #5 had a charge of $15.00 for ID bracelets. There was no indication of a deposit/withdraw for $140.00 for a wander guard bracelet for Resident #4 & #5.

Interview of the Accountant indicated that monies received (from Resident #4 & #5) for payment of wander guards($140.00) were deposited directly into the home's bank account.

The severity of the harm and risk of harm to residents arising from non-compliance was very high. All residents were charged for ID bracelets and 2 residents were charged for wander guard bracelets. The scope of the harm and risk of harm arising from non-compliance is widespread as all residents were charged for ID bracelets as identified in the inspection report.

The licensee failed to ensure that residents were not charged for anything that the regulations provide is not to be charged for. [s. 91. (4)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 09, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 8th day of October, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LYNDA BROWN

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