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 # / Registre no	Type of Inspection / Genre d'inspection
Jun 28, 2017	2017_562620_0007	005880-17	Resident Quality Inspection

Licensee/Titulaire de permis

WIKWEMIKONG NURSING HOME LIMITED
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

WIKWEMIKONG NURSING HOME
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

ALAIN PLANTE (620), MICHELLE BERARDI (679), SARAH CHARETTE (612)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 18-21, and April 24-28, 2017

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.

Logs inspected during this complaint inspection included:

- three incidents related to a resident falls,

- two incidents related to a controlled substance missing/unaccounted for,

- an incident related to resident to resident physical abuse,

- a follow-up to compliance order #001 of report #2016_395613_0003 related to O.Reg 79/10 s. 9. (1), which required the home to ensure that all doors leading to the outside of the home were secured as required,

- an incident related to resident to resident sexual abuse, and

- one complaints related to staff to resident sexual and financial abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOCs), Maintenance Manager, Office Manager/Finance Officer, Registered Dietician (RD), Registered Nurses (RNs), Activities Supervisor, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Receptionist, Housekeeping Staff, residents, and residents' family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
22 WN(s)
12 VPC(s)
5 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 9. (1)	CO #001	2016_395613_0003	612

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. 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 has failed to ensure that all residents were protected from abuse by anyone.

Inspector #679 reviewed a complaint received by the Director. The complainant suspected that resident #011 had been sexually abused by a staff member in the home.

With regards to the allegation of sexual abuse toward resident #011 by staff, the Inspector was unable to identify any grounds to support that staff to resident abuse had occurred. However, there were grounds to support that an individual known to resident #011 had exhibited abusive actions upon resident #011 and other residents in the home.

Inspector #679 reviewed resident #011's electronic progress notes. The review of the electronic progress notes for resident #011 revealed the following related to suspicion of verbal, financial, and emotional abuse directed toward resident #011 by an individual known to them:

- RPN #105 documented that an individual known to resident #011 had been witnessed verbally and financially abusing the resident; this caused the resident to cry. RPN #105 indicated that they advised the individual that their behaviour was upsetting resident #011, and could be upsetting other residents. RPN #105 indicated that they notified the ADOC of the incident and that they were directed to notify the police, and did so.

- RPN #105 documented that the police arrived at the home and had an individual known to resident #011 removed from the property.

- The DOC documented that a PSW reported to them that an individual known to resident #011 had been verbally aggressive toward resident #011, other resident's in the home and staff. The documentation indicated that the DOC and the Administrator spoke with both resident #011 and the individual regarding the verbally aggressive behaviour, and that during the conversation, the individual continued to use foul language and an aggressive tone with both the Administrator and the DOC.

- RN #104 documented that they observed resident #011 crying. When RN #104 asked about what had upset them, they indicated that they had been discussing financial issues with an individual known to them and the conversation had been upsetting.

- A complaint was brought forward to Residents' Council by resident #011. They indicated that an individual known to them did not feel welcome by others in the home. A progress note indicated that the Administrator and the DOC explained to resident #011 that the individual known to them posed a threat to both residents and staff with regards

behavior, and both residents and staff felt threatened and afraid of this individual.

- The DOC documented that they had notified the Physician about the, "disruptive behaviour" being exhibited by an individual known to resident #011, and that resident #011 and the organization could benefit if a peace bond or a trespass notice were in place. The DOC then notified the police service and the Elder Abuse Coordinator regarding the suspected emotional, and financial abuse from the individual known to resident #011.

- The DOC documented that the police service had advised the home to issue a trespass notice and a peace bond to protect the residents and staff from the individual known to resident #011.

- RPN #105 documented that an individual known to resident #011 had entered the home following the issuance of a peace bond and no trespass order. They indicated that the police were notified and the individual was removed from the premises by two Officers. The progress note detailed that the individual had verbally abused another resident (resident# 017). The note also indicated that resident #011 had indicated that the individual was abusive and that they were taking their money.

According to the LTCHA, 2007, s. 23 (1), every alleged, suspected or witnessed incident of the following that the licensee knows of, or that was reported to the licensee, was immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action was taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with.
Non-compliance related to s. 23 (1), of the LTCHA, 2007, was identified; please refer to WN #11 contained within this report for further details.

According to the LTCHA, 2007, s 20 (1), Without in any way restricting the generality of the duty provided for in section 19, every licensee shall 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. Non-compliance related to s. 20 (1), of the LTCHA, 2007, was identified; refer to WN #10, contained within this report for further detail.

According to the LTCHA, 2007, s 24 (1), any person who had reasonable grounds to suspect that any of the following had occurred or may have occurred shall immediately report the suspicion and the information upon which it was based to the director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident. Non-compliance related to s. 24 (1), of the LTCHA, 2007, was identified; refer to WN #3-3, contained within this report for further detail.

According to O.Reg. 99. (b), every licensee of a long-term care home was to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences. Non-compliance related to O.Reg. 99. (b), was identified; refer to WN #5 contained within this report for further detail.

In conclusion, the licensee failed to ensure that the home's policy to promote zero tolerance of abuse was complied with, failed to investigate, failed to report suspected \alleged abuse to the Director, and failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was evaluated.

In an interview with Inspector #679 RN#105 identified that resident #011 communicated to them that an individual known to them was financially, verbally and emotionally abusive towards them, and that they were scared of them. RN #105 stated that they informed the DOC about the conversation.

In an interview with the DOC they confirmed that the home was aware of the instances of emotional and verbal abuse and that the home suspected financial abuse, stating "the abuse was very evident" but did not report any of the instances to the Director. [s. 19. (1)]

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident’s money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may have occurred immediately reported the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Resident #010 reported to Inspector #679 that about a year ago a staff member had treated them roughly. Inspector #620 immediately reported the information to the DOC.

Inspector #612 reviewed the Critical Incident reports submitted by the home and was unable to locate any CI reports filed relating to this allegation of rough treatment that was reported to the DOC by Inspector #620.

Inspector #612 interviewed the DOC who stated that they had not notified the Director about the alleged abuse which was reported to them by Inspector #620.

Inspector #612 reviewed the home's policy titled, "Abuse and Neglect Prevention Program", subsection 3.2, last revised June, 2015. The policy stated that upon becoming aware of an alleged act of abuse, the Administrator/Designate was to notify the Ministry of Health and Long-Term care immediately via Critical Incident Reporting System, or via pager (after hours or holiday). The policy also included a reference to Mandatory

Reporting of Abuse or Neglect under section 24 of the LTCHA, 2007.

Inspector #612 reviewed a memo from the Director, sent to all Long-Term Care Homes, dated March 28, 2012, which stated that any person who had reasonable grounds to believe that a resident had been abused or neglected must immediately report the suspicion to the Director under section 24 of the LTCHA, 2007.

Inspector #612 was provided with the investigation notes by the DOC. In the notes, the DOC stated that because of the lack of dates and times for the incident, a Critical Incident report could not be submitted as the allegation was a mandatory requirement for submission. [s. 24. (1)]

2. During a resident interview, resident #007 indicated to Inspector #679 that they had been treated roughly by staff. The resident also indicated that staff had yelled at them on occasion.

Inspector #620 immediately advised the home's DOC of the allegation of abuse that resident #007 had disclosed.

The DOC indicated that they began their investigation when they were notified by Inspector #620 of the allegation of abuse.

Inspector #620 reviewed the Critical Incident Reporting System to identify if the home had immediately submitted a critical incident report related to the allegation of abuse. The Inspector was unable to identify that the home had submitted a CI report for the allegation that had been reported to them by Inspector #620.

Inspector #612 interviewed the DOC who stated that they had not submitted a CI report or notified the Director about the alleged incident of abuse that resident #007 had reported to Inspector #679 which was reported to them by Inspector #620. [s. 24. (1)]

3. Inspector #679 reviewed a complaint received by the Director. The complainant suspected that resident #011 had been sexually abused by a staff member in the home.

Inspector #620 reviewed resident #011's electronic progress notes and identified ten individual progress notes that were documented; the notes indicated that the ADOC, DOC, and the Administrator were aware of actual/suspected verbal, emotional, and financial abuse directed toward resident #011 by an individual known to them. There was

also a documented incident of verbal abuse towards resident #017 by the individual. For further detailed information related to the incidences refer to WN#11 within this inspection report.

Inspector #679 reviewed the home's abuse policy titled "Section 3 Residents Rights and Safety: Abuse and Neglect Prevention Program", last revised June 2015, which indicated that "all staff and volunteers of the home were expected to fulfill their moral and legal obligation to report any incident or suspected incident of resident abuse". The policy then described that the Administrator was to notify the MOHLTC via CIS or via pager (after hours or holidays) of any incident of suspected/actual incident of abuse.

Inspector #679 reviewed the MOHLTC's Critical Incident Reporting System (CIS). The Inspector was unable to identify any indication that the home had submitted a report of alleged or suspected abuse to the Director for any of the incidences that were documented in the resident's progress notes.

In an interview with the DOC they confirmed that the home was aware of the instances of emotional and verbal abuse, as well as, the suspicion of financial abuse when they stated, "the abuse was very evident." The DOC verified that they had not reported any of the instances of actual/suspected abuse to the Director. [s. 24. (1)]

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. 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 has 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 section 48 of the regulation; specifically, there was no written description of the program that included its goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

During stage one of the RQI, resident #002 and #009 were identified to have experienced a significant weight change. Upon review of resident #002's recorded weights in the home's electronic health record, Point Click Care (PCC), it was identified that they had experienced a significant weight change. Resident #009 had also experienced a significant weight change.

During an interview with Inspector #679, RPN #105 identified that if there was a

discrepancy in the resident's weight, the PSWs were to complete a re-weigh. If there was a noted significant weight change after a re-weigh, then a referral was to be sent to the RD through PCC.

During an interview with Inspector #612, the RD stated that they were unaware of the significant weight change experienced by resident #002 and #009. They stated that the registered staff would input the weights into PCC and complete a referral to the RD if there was a significant weight change through PCC. The RD stated that they had not received a referral.

The Inspector reviewed the home's policy titled, "Feeding and Hydration Program", subsection 11.1, date of origin August 13, 2017. Under the heading "Hydration Policy" the document described that the PSWs were to obtain the residents' weights on a monthly basis and re-weigh if there was a variance in the monthly weight of two kilograms or more. The policy did not address the referral process to the interdisciplinary team members, including criteria for a referral, and the process to complete a referral.

Inspector #612 interviewed the RD and confirmed that the home's Dietary Services and Hydration Program did not include a written descriptions of procedure for referral to the RD and to specialized resources. [s. 30. (1) 1.]

2. The licensee has failed to ensure that the home's Continence Improvement Program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Non-compliance related to continence was identified for resident #006 (for details please refer to WN #13-1), and resident #009 (for details please refer to WN #1-4 and WN #13-2).

During a record review, Inspector #679 identified that the home's Continence Improvement policy titled, "Section 12: Continence Care and Bowel Management Program" was last revised in December, 2015.

A review of the home's Continence Improvement policy identified that Registered Nursing Staff were required to, "Annually evaluate the program and the effectiveness of the continence care and bowel management. A written record will be kept of the program review and will include the name and relevant discipline of the individuals."

During an interview with inspector #679, the DOC confirmed that the home’s Continence Improvement Policy had not been reviewed annually and that the last review was completed in December, 2015. [s. 30. (1) 3.]

3. The licensee has failed to ensure that the home’s Falls Prevention and Management Program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Non-compliance related to falls prevention and management was identified for resident #001 (for details please refer to WN #18), and resident #009 (for details refer to WN #1-4).

Inspector #612 reviewed the Falls Prevention Program as provided by the DOC and noted that the date of the last review was identified as June, 2015. The document titled, “Falls Prevention Program,” subsection 3.6, stated that the Interdisciplinary Falls Team was to review the falls management program annually to determine the effectiveness of the program and to identify changes to improve the program. The team was also required to provide a written evaluation of the Falls Management Program annually to the Quality Management Committee.

On April 26, 2017, Inspector #612 interviewed the DOC who stated that the policy had not been reviewed annually and was last reviewed in 2015. [s. 30. (1) 3.]

4. The licensee has failed to ensure that the home’s Skin and Wound Program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Non-compliance related to skin and wound care was identified for resident #003 (for details please refer to WN #19-2), and resident #008 (for details please refer to WN #1-1).

During a record review, Inspector #679 identified that the home’s Skin and Wound Policy, titled, “Section 16: Wound and Skin Care Program” was dated August, 2013.

A review of the home's Skin and Wound policy identified that “The Wound and Skin Care Committee shall review the Wound and Skin Care Program annually to determine the effectiveness of the program and to identify changes to improve the program. The Wound and Skin Care Committee shall provide a written evaluation of the program

annually to the Quality Management Committee.”

During an interview with Inspector #679, the DOC identified that the home’s Skin and Wound Care policy had not been updated annually, and that it was last updated in August, 2013. [s. 30. (1) 3.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee’s policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

Non-compliance related to zero tolerance of abuse and neglect of residents was identified for resident #007 (for details please refer to WN #3-2), and resident #010 (for details please refer to WN #3-1), and resident #011 (for details please refer to WN #2, WN #3-3, and WN #11).

Inspector #612 reviewed the home's policy titled, "Abuse and Neglect Prevention Program", subsection 3.2 and noted that the last date revised was June 2015.

On April 26, 2017, Inspector #612 interviewed the DOC who stated that the policy had not been reviewed or evaluated since June 2015. [s. 99. (b)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

During stage one of the Resident Quality Inspection, Inspectors #679 and #612 identified four resident beds (#002, #003, #006 and #017) in which there was an approximately 20 centimeter gap between the mattress and the footboard or the mattress and the headboard of the bed.

In an interview with RPN #105, they stated that staff observe for entrapment zones once the mattress is put onto the bed frame. If there is any abnormalities then the mattress is changed. RPN #105 stated there was no formal process for assessing the entrapment zones.

In an interview with Inspector #679, the Maintenance Manager stated that the home did not conduct an assessment of each resident's bed system and potential zones of entrapment.

A review of the home's policy titled "Resident Services Manual: Section 3 Resident Safety" dated July 2012, outlined that the home was to establish an interdisciplinary group that would accept responsibility for measuring existing bed systems and taking corrective actions when indicated. The policy then identified that the home was to assess the beds within the home to ensure that entrapment zones and risks were identified.

A memo from the Ministry of Health and Long-Term Care (MOHLTC) dated August 21, 2012 was sent to all Long-Term Care (LTC) Home Administrators indicating that all LTC homes should use the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards' as a best practice document in their homes. This document referenced the 'Clinical Guidance for the Assessment and implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings' (CGA), as a prevailing practice for assessing the use of bed rails. The memo informed all LTC homes that they were required to conduct assessments for zones of entrapment; specifically but not limited to zone 7, the zone between the head or foot board and the end of the mattress.

In an interview with Inspector #679, the DOC confirmed that there was no assessment conducted by the home to assess each resident bed for entrapment zones. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

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

During stage one of the Resident Quality Inspection (RQI), it was identified during a resident observation and subsequent staff interview that resident #008 had specific care needs.

Inspector #679 observed PSW #114 exiting resident #008's room alone with a transfer device.

During an interview with Inspector #679, PSW #114 confirmed that they had transferred the resident alone, without assistance.

A review of the resident's electronic care plan identified that resident #008 required two staff to complete resident #008's transfer.

Inspector #679 interviewed RPN #105, regarding the home's policy on the use of transfer device. RPN #105 identified the home's policy stated that any person using a transfer device would require two staff; one staff member to assist with guiding, and one for operating the transfer device. RPN #105 indicated that this was done so that if something went wrong, a staff member would be there to assist the resident.

A review of the home's policy titled, "Resident Services Manual Section 8.0 Safe Lifting and Handling Residents" dated August, 2013, identified that employees were to, "follow

the designated lift/transfer technique as documented on each resident's care plan.”

During an interview with the DOC on April 26, 2017, they confirmed that all transfer devices were to be used in the presence of two staff. [s. 6. (7)]

2. During a tour of the home, Inspector #612 observed PSW #115 transferring resident #016 with transfer device, without the assistance of another staff member.

Inspector #612 reviewed resident #016’s current electronic care plan. Under the focus of transferring the care plan advised staff that resident #016 required two staff to assist with transfer with the use of a specific transfer device.

Inspector #612 interviewed PSW #115 who stated that resident #016 required two staff to assist with a specific transfer device. [s. 6. (7)]

3. Following stage one of the RQI, resident #009’s Minimum Data Set (MDS) assessment instrument identified that the resident had a prevalence of falls and the resident had a fall within the past 30 days according to the most recent assessment.

Inspector #679 reviewed the electronic plan of care for resident #009 and identified that under the focus of falls that the resident was to have a certain device in place in a manner that it would be operable.

Inspector #679 observed that the resident’s device was in place; however, the device was not applied in a way that would render it operable.

During interviews with PSWs #107, #112 and RPN #105, they confirmed that the device was not applied correctly and that it was inoperable.

During an interview with Inspector #679, RN #104 identified that the specific device was to be in place for resident #009 and that it was to be applied in such a manner that it was operable. [s. 6. (7)]

4. Following stage one of the RQI, resident #009’s MDS assessment instrument identified that the resident had experienced a change in continence since their admission.

Inspector #679 reviewed resident #009’s plan of care, which identified that the resident

was to receive a certain intervention related to their continence.

Inspector #679 observed that the continence intervention was not being provided for resident #009.

During an interview with PSWs #112 and #114, they identified that resident #009 was not receiving the continence intervention.

In an interview with inspector #679, RN #104 stated that staff had not followed the resident's care plan as staff had failed to ensure that the continence intervention was provided for resident #009. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse (RN) who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

During one of the home's scheduled day shift, Inspector #620 was unable to locate a RN who was both an employee of the licensee and a member of the regular nursing staff of the home.

Inspector #620 conducted a document review of the RN staffing schedule in the home. The review revealed that during a 31 day interval, the home was without 24/7 RN staff 19 per cent of the reviewed time period.

Inspector #620 interviewed the home's Office Manager who indicated that all staff who worked a shift were required to utilize a fingerprint recognition device to indicate that they were present and working in the home. The office Manager identified that there was no staff RN present in the facility on the dates identified by Inspector #620.

Inspector #620 interviewed the home's Administrator and DOC, both indicated that the home had struggled to retain RN staffing. They indicated that on two specific days, there was no RN on site. The DOC stated that in addition to the two days, on four other occasions, there was no RN who was a member of the regular nursing staff on site in the home; but rather, the home had an Agency RN on site. When asked if there was an emergency that prevented the RN from attending their regularly scheduled shift, the DOC indicated no. The DOC indicated that they had decided to use an Agency RN because there were not enough staff available in their staffing roster to fill all vacant shifts. [s. 8. (3)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On April 20, 2017, during stage one of the RQI, Inspector #620 observed a common area in disrepair; specifically, it was observed that the sink in a certain room had a crack in proximity to the drain. Further observation by Inspector #612, #620, and #679 revealed the following:
- Untitled shower room; the shower tray had cracked caulking with black colored mold, the tile flooring adjacent to the shower tray was delaminated with signs of water infiltration, portions of the floors tiles were missing and there was a portion of baseboard missing,
- Untitled room; Wall surfaces with damaged paint, and a scratched entry door,
- Untitled room; Ceiling had an unpainted drywall repair and wall surfaces with damaged paint,
- Untitled room; Wall surfaces with damaged paint,
- Untitled room; Wall surfaces with damaged paint and stained tiles under the sink,
- Untitled room; Wall surfaces with damaged paint,
- Untitled room; Wall surfaces with damaged paint,
- Untitled room; Unpainted drywall repairs, missing tile adjacent to sink, damage to lower wall surfaces,
- Untitled room; Unpainted drywall repairs, and
- Untitled room; Missing tile, cracked and soiled caulking around the base of the toilet, and missing door trim.

Inspector #620 interviewed the home's Maintenance Manager. The Maintenance Manager indicated that they were aware of the damaged flooring in the West Shower room. They indicated that there was currently no plan in place to ensure that a repair was to be completed. The Maintenance Manager acknowledged that the West Unit of the home was an older area and that it was in need of repair. Inspector #620 asked the Maintenance Manager for documentation related to routine maintenance for addressing maintenance related concerns; the Maintenance Manager indicated, none existed. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #9: 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 has failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

Inspector #679 reviewed a complaint received by the Director. The complainant suspected that resident #011 had been sexually abused by a staff member in the home. For further detail please refer to WN #2 within this inspection report.

Inspector #679 reviewed the homes abuse policy titled "Section 3 Residents rights and safety: Abuse and neglect prevention program", last revised June 2015, which indicated that "all staff and volunteers of the home were expected to fulfill their moral and legal obligation to report any incident or suspected incident of resident abuse." The policy then described that the Administrator was to notify the MOHLTC via CIS or via pager (after hours or holidays) of any incident of suspected/actual incident of abuse. Additionally, the policy indicated that upon the completion of the investigation a Critical Incident Report is to be received by the Ministry of Health and Long-Term Care.

Inspector #679 reviewed the MOHLTC’s Critical Incident Reporting System (CIS). The Inspector was unable to identify any indication that the home had submitted a report of alleged or suspected abuse to the Director for any of the incidences that were documented in the resident’s progress notes. For further details refer to WN #2 within this report.

Inspector #679 conducted a review of the home’s documentation and was unable to identify any indication that the home had conducted an investigation related to the known/suspected incidents of abuse. For further details refer to WN #11 within this report.

Inspector #679 completed a review of the CIS and discovered that no critical incident (CI) reports were submitted to the Director, outlining the incidents of abuse towards resident #011 by an individual known to them.

In an interview with Inspector #679, the DOC confirmed that they suspected that resident #011 had been emotionally, verbally, and financially abused by an individual known to them. They indicated that home had not conducted a formal investigation related to the witnessed or suspected incidents of abuse; nor had they reported the incidences of abuse to the Director as was required by the home’s policy on zero tolerance of abuse. [s. 20. (1)]

Additional Required Actions:

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

WN #10: 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. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse or neglect of a resident by anyone that the licensee knew of, or that was reported to the licensee, was immediately investigated.

The Long Term Care Homes Act 2007, defines verbal, emotional, and financial abuse as:
"Verbal abuse" means,
(a) Any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of wellbeing, dignity or self-worth, that is made by anyone other than a resident, or
(b) Any form of verbal communication of a threatening or intimidating nature made by a

resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences;
"Emotional abuse" means,
(a) Any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or
(b) Any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.
"Financial abuse" means,
Any misappropriation or misuse of a resident's money or property.

Inspector #679 reviewed a complaint received by the Director. The complainant suspected that resident #011 had been sexually abused by a staff member in the home.

Inspector #679 reviewed resident #011's electronic progress notes. The review of the electronic progress notes for resident #011 revealed the home suspected financial abuse and documented verbal and emotional abuse directed toward resident #011 by an individual known to them. For details related to the incidents please refer to WN #2.

A review of the home's policy titled "3.3 Abuse and Neglect Prevention Program", last revised in June 2015, outlined that for any suspected or witnessed incident of abuse or neglect, "the manager shall investigate all incidents. The investigation shall include: an interview with the resident, and interview with the accused staff/volunteer/visitor, an interview with the staff or person who reported the incident and in interview with all witnesses or others involved". The policy further identified that "a detailed description of the incident is to be documented on the resident's care record that clearly describes the incident. The documentation is to outline the physical findings and care/treatment provided to all involved".

Inspector #679 conducted a review of the home's documentation and was unable to identify any indication that the home had conducted an investigation into any of the suspected incidents of abuse by the individual known to resident #011 or towards other residents.

In an interview with Inspector #679, the DOC confirmed that they suspected that resident #011 had been emotionally, verbally, and financially abused by an individual known to them. They indicated that home had not conducted a formal investigation related to the

witnessed or suspected incidents of abuse. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that every alleged, suspected or witnessed incident of abuse or neglect of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

During the course of a document review related to 24/7 RN staffing inspector #620 was unable to locate a written staffing plan. Non-compliance related to 24/7 RN staffing was identified, for details please refer to WN #7.

Inspector #620 interviewed the home’s Administrator and DOC, both indicated that the home did not have a written staffing plan and that they were unaware that a written staffing plan was required. [s. 31. (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 ensuring that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2), to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Following stage one of the RQI, resident #006's MDS assessment instrument identified that the resident had experienced a change in continence since admission.

Inspector #679 reviewed the MDS assessment which indicated that resident #006 was admitted with a specific level of continence. A review of the electronic Bowel and Bladder Continence Assessment Instrument, revealed the same continence designation.

The most recent MDS assessment at the time of inspection identified that the resident had experienced a change in continence.

Inspector #679 reviewed resident #006’s Point of Care (POC) charting and identified that during a certain period of 13 days, the resident exhibited a continence decline. Over the most recent 14 days at the time of inspection, the resident exhibited three instances of continence decline.

Inspector #679 reviewed the electronic assessments and could not locate a completed Bowel and Bladder Continence Assessment Instrument related to resident #006’s continence decline.

In an interview with RPN #105, they indicated that a Bowel and Bladder Continence Assessment Instrument was to be completed on admission for any resident who experienced incontinence as well as when there was a change in incontinence.

A review of the home's Continence Policy entitled "Section 12.1 Continence Care and Bowel Management Program”, last revised December 2015, identified that registered staff should, "collaborate with the resident, SDM, and the interdisciplinary team to conduct a bowel and bladder continence assessment utilizing a clinically appropriate instrument: on admission, quarterly and after any change in condition that may affect bladder or bowel continence."

In an interview with Inspector #679, the DOC indicated that it was the expectation of the home that a Bowel and Bladder Continence Assessment Instrument was to be completed upon admission for a resident experiencing incontinence, quarterly, or upon a significant change in continence, and that this had not occurred for resident #006. [s. 51. (2) (a)]

2. Following stage one of the RQI, resident #009’s MDS assessment instrument identified that the resident had experienced a continence decline since admission.

Inspector #679 reviewed the admission MDS assessment, for resident #009 which identified that on admission to the home the resident was assessed with a certain degree of continence.

A review of the most recent MDS assessment, identified that the resident exhibited a continence decline.

A review of resident #009’s care plan, current at the time of inspection, identified a focus related to continence. The care plan indicated the goal was to maintain skin integrity and continence. Specific interventions were designated to be provided for resident #009.

Inspector #679 reviewed the electronic assessments, and could not locate any indication that a Bowel and Bladder Continence Assessment Instrument had been completed. [s. 51. (2) (a)]

Additional Required Actions:

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

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that procedures were developed and implemented for addressing incidents of lingering offensive odours.

On three separate occasions, during stage one of the RQI, Inspector #679 observed that

specific common area of the home had a lingering offensive odour of urine.

For four days Inspector #620 conducted numerous daily observations of a specific common area of the home; for every observation, a lingering offensive odour of urine was present.

Inspector #620 interviewed Housekeeping Aide #123. They indicated that if there were offensive odours in the home they could utilize deodorizing sprays. Housekeeping Aid #123 was unaware if there was any policy/procedure that identified how to manage the odours.

Inspector #620 interviewed Housekeeping Aide #124. They indicated that they worked solely in a specific area of the home. When asked about the smell of urine in the area of the in which they worked, Housekeeping Aide #124 indicated that they were aware that there was a lingering odour of urine. They stated that the odour may be lingering because on some occasions residents urinated in inappropriate areas. Housekeeping Aide #124 denied any knowledge of any existing policy/procedure that provided them direction for dealing with lingering offensive odours.

Inspector #620 interviewed the home’s Maintenance Manager who indicated that they were lead for both Housekeeping and Maintenance in the home. When asked about the odour of urine in the specific area of the home, the Maintenance Manager acknowledged that there was a strong odour of urine and that it was an ongoing issue. The Maintenance Manager indicated that the home's organized program of housekeeping did not have any procedure(s) developed and implemented for addressing incidents of lingering offensive odours.

Inspector #620 interviewed the DOC about the odour of urine in the certain area of the home. The DOC indicated that they were aware of the odour as their office was recently moved from that area of the home. The DOC was unaware of any policy/procedure for addressing incidents of lingering offensive odours. They indicated that the odour was likely a result of certain residents urinating in inappropriate areas.

Inspector #612 interviewed the home’s Administrator who stated that they were aware of the odour that was present in a certain area of the home. They identified that there were currently no policies/procedures in place for managing offensive odours in the home. They indicated that there were policies/procedures in draft form; however, the documents were still incomplete and not yet implemented. [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, ensuring that a monthly audit was undertaken of the daily count of controlled substances to determine if there were any discrepancies and that immediate action was taken if any discrepancies were discovered.

During an interview with RPN #105, they stated to Inspector #612 that they would provide the completed daily narcotic count sheets to the DOC at the end of the month.

The Inspector interviewed the DOC; they stated that they kept all the daily narcotic count sheets in a binder. They stated that they were supposed to complete an audit monthly; however, they had not completed the audit for the last two months.

The Inspector reviewed the binder and noted that the most recent audit of the daily narcotic count was completed three months previous.

The Inspector reviewed the home's policy titled "Shift Change Monitored Drug Count", policy number 6-6, last reviewed February 2017, which stated that a monthly audit of all shift count was required by the DOC, manager or delegate, and it was to be compared to the quantity of medication remaining. [s. 130. 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that steps are taken to ensure the security of the drug supply, ensuring that a monthly audit is undertaken of the daily count of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered, to be implemented voluntarily.

WN #15: 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. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Inspector #612 observed a medication pass. The Inspector observed that RPN #105 conduct a specific assessment for resident #019. The RPN administered the resident's scheduled medication based on their assessment and proceeded to the next resident to continue with their medication pass.

Inspector #612 reviewed resident #019’s electronic Medication Administration Record (eMAR) and noted that there was an order which advised registered staff to administer a certain medication based on certain assessment criteria that was required before administration. The Inspector noted that since the medication was ordered, there were 17 occasions where the resident’s assessment required the administration of a certain medication. The resident did not receive the medication on 14 occasions or 82 percent of the time when they should have.

Inspector #612 interviewed RPN #105. They stated that they did not administer the medication as ordered as the order was not clear to them. They stated that they only found out about the order on a certain date, and they planned to request that the physician clarify the order via a referral process through Point Click Care.

The Inspector reviewed a medication administration policy which stated that a certain medication represented a high risk and should be administered as ordered. The policy stated to double check the eMAR to ensure that you have the right resident, right dose and the right time. [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 ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident’s health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident’s substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident’s attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident’s health; and
(b) reported to the resident, the residents substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident’s attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Inspector #612 observed a medication pass. The Inspector observed that RPN #105 conduct a specific assessment for resident #019. The RPN administered the resident's scheduled medication based on their assessment and proceeded to the next resident to

continue with their medication pass.

Inspector #612 reviewed resident #019’s electronic Medication Administration Record (eMAR) and noted that there was an order which advised registered staff to administer a certain medication based on certain assessment criteria that was required before administration. The Inspector noted that since the medication was ordered, there were 17 occasions where the resident’s assessment required the administration of a certain medication. The resident did not receive the medication on 14 occasions or 82 percent of the time when they should have.

The Inspector reviewed the home’s policy titled “Medication Incident Reporting”, policy 9-1, last reviewed February 2017, which stated that, “a medication incident was defined as any preventable event that may cause or lead to inappropriate medication use or client harm while the medication was in the control of the health care professional, client or consumer. Such events may be related to professional practice, health care products, procedures and systems, including prescribing; order communication, product labelling’ packaging and nomenclature; compounding; dispensing; distribution; administration; education; monitoring and use.”

The document indicated that the, “medication incident report should be completed when a medication incident or adverse drug reaction has occurred including near miss situations. This can be completed via an online reporting system, by phone or by fax. Every medication incident and adverse drug reaction involving a resident (excluding near miss) should be reported to the resident, or the resident’s substitute decision-maker, the Director of Nursing and Personal Care, the resident’s attending physician and the pharmacy.”

Inspector #612 interviewed RPN #105. They stated that they did not administer the medication as ordered as the order was not clear to them. They stated that they only found out about the order on a certain date, and they planned to request that the physician clarify the order via a referral process through Point Click Care. RPN #105 stated that they had not completed a medication incident report.

On April 26, 2017, the Inspector interviewed the DOC. The DOC stated that they were not aware of the order, but that it was a medication error as staff were not administering the medication as per the order. The DOC stated that the expectation would be for staff to complete a Medication Incident report. They also stated that staff should have contacted the physician for clarification.

The Inspector interviewed the DOC and they stated that a medication incident report had not been completed; however, they had spoken with staff about the order. The Inspector interviewed RPN #116 who stated that they were unaware of the order, but that they planned to contact the Physician for clarification and complete a medication incident report online. [s. 135. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that every medication incident involving a resident and every adverse drug reaction is
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the residents substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Infection Prevention and Control Program

was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Non-compliance related to the implementation of the home's Infection Prevention and Control Program was identified for details please refer to WN #3-2.

Inspector #612 reviewed the home's "Infection Prevention and Control Program" and noted that the date of last revision was August 2013. The document stated that the Infection Control Committee was to develop and approve policies and procedures for all aspects of the Infection Prevention and Control Program was to be reviewed annually and improvements made as required.

Inspector #612 interviewed the DOC who stated that the Infection Prevention and Control Program, including all the policies, had not been reviewed annually.

Inspector #612 interviewed the Administrator who stated that the Infection Prevention and Control Program, including all the policies, had not been reviewed since the date of origin, in August 2013. [s. 229. (2) (d)]

2. The licensee has failed to ensure that staff participated in the implementation of the Infection Prevention and Control Program.

Inspector #612 and #620 observed a nurse providing foot care to a resident in a common area of the home. Inspector #612 observed the nurse move to a treatment room to provide foot care to a different resident.

The Inspector reviewed the home's policy title, "Infection Prevention and Control Program", subsection 1.1, dated August 2013. The document indicated that, “routine practices were based on the premise that all residents were potentially infectious, even when asymptomatic, and that the same safe standards of practice should be used routinely with all clients/patients/residents to prevent exposure to blood, body fluids, secretions, excretions, mucous membranes, non-intact skin or soiled items to prevent the spread of microorganisms. Routine practices by all health care providers with all resident encounters will lessen microbial transmission in the home and reduce the need for additional precautions. Health care providers must assess the risk of exposure to blood, body fluids and non-intact skin and identify the strategies that will decrease exposure risk and prevent the transmission of microorganisms. Health care providers are accountable to practice safely in a manner that protects residents and themselves by following

established organizational infection prevention and control policies and procedures.”

Inspector #612 interviewed the DOC who confirmed that the nurse had provided nail care to a resident in a common area of the home and should not have. The DOC stated that as soon as they saw the nurse providing the care in the common area, they redirected them to provide the care in the treatment room or in a resident’s bedroom only. [s. 229. (4)]

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 ensuring that the Infection Prevention and Control Programs evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and ensuring that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, an interdisciplinary assessment of health conditions, including allergies, pain, risk of falls, and other special needs.

During stage one of the RQI, resident #001 was identified through the Resident Assessment Instrument - Minimum Data Set (RAI/MDS) review as has having had a fall within the last 30 days.

Inspector #612 reviewed resident #001's assessments in PCC and identified that resident #001 had experienced falls.

Inspector #612 reviewed resident #001's current electronic plan of care and was unable to find a focus, goals, or interventions related to fall risk, or falls prevention.

Inspector #612 reviewed resident #001's assessments in PCC and noted that a Falls Risk Assessment was completed on a certain date. The assessment identified that the resident was designated a certain risk for falls. The corresponding progress note stated that resident #001 was assessed for a specific falls risk and that the care plan was updated to reflect interventions.

The Inspector reviewed the home's policy titled, "Falls Prevention Program," subsection 3.6, dated June, 2005, which stated that the interdisciplinary team would develop interventions to address residents identified at risk for falling, and implement an interdisciplinary plan of care. The Interventions were to be based on the level of risk and the written plan of care updated as necessary.

Inspector #612 interviewed RPN #105 who stated that resident #001 previously had a focus, goals and interventions related to falls risk in their care plan; however, the items had been resolved and subsequently removed from the care plan. RPN #105 did identify that the resident remained at a specific risk for falls and that staff were not implementing interventions to prevent falls.

Inspector #612 interviewed the DOC; they stated that resident #001 remained at a specific risk for falls; as a result, they would expect a related focus, goal, and interventions be included in the residents care plan. [s. 26. (3) 10.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff.

Following stage one of the RQI, resident #008’s MDS assessment instrument identified that the resident had altered skin integrity.

In an interview with RPN #105, they indicated that when there was any impairment in skin integrity exhibited by a resident, a Bates Jensen Weekly Wound Assessment (BWAT) assessment should be completed weekly. They indicated that resident#008 had areas of altered skin integrity and that one BWAT assessment would serve as a weekly wound assessment for all of the resident’s areas of altered skin integrity.

A review of resident #008’s BWAT assessment that was documented upon admission indicated that the resident was assessed to have specific areas of altered skin integrity.

A review of resident #008’s BWAT assessment records at the time of inspection indicated

that the resident was assessed to have areas of altered skin integrity.

Inspector #679 reviewed the electronic progress notes and the BWAT records for resident #008, which identified that the BWAT assessments were not completed on weekly intervals for resident #008 for nine consecutive months.

A review of the home’s Wound and Skin Care Program titled, "Section: 16 Wound and Skin care program" dated August 2013, identified that, "All open areas will be assessed weekly by the Registered Staff using the Bates Jensen Weekly Wound Assessment. The Bates Jensen Weekly Wound Assessment Tool was developed to monitor for changes in pressure ulcer status over time. The Bates Jensen wound assessment tool will provide Registered Staff with a determination of wound healing over time."

In an interview with Inspector #679, the DOC indicated that it was the expectation of the home that when a resident experienced any impairment in skin integrity, staff were required to complete a BWAT assessment weekly, and that this had not occurred for resident #008. [s. 50. (2) (b) (iv)]

2. During stage one of the RQI, resident #003 was identified through a staff interview and census review as having altered skin integrity.

Inspector #612 reviewed the resident’s electronic treatment record (eTAR) and noted that there was no signature indicating that a weekly BWAT assessment was completed by the registered staff for 12 days.

The Inspector interviewed RPN #105 who stated that the weekly wound assessments are completed in the progress notes, under the focus titled, "BWAT Wound Assessment." RPN #105 stated that they would also check off that it was completed in the eTAR after they completed the progress note. RPN #105 stated that they were unable to find a progress note, titled, "BWAT Wound Assessment."

Inspector #612 interviewed the DOC who stated that the BWAT wound assessment progress note were to be completed weekly as the registered staff were prompted to do so in the eTAR. [s. 50. (2) (b) (iv)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Nutrition and Hydration Program included the implementation of interventions to mitigate and manage risks.

During stage one of the RQI, Inspector #612 identified residents from the census sample without weights recorded. Residents #001, #002, #006, #009, #020, #021, #022, #024, #025, and #026, were missing a recorded weight.

Inspector #612 interviewed RPN #105; they stated that weights were expected to be obtained on a monthly basis by the PSWs. They stated that the weights collected by the PSWs were then to be given to the night shift registered staff who would then enter them into the weights and vitals section in Point Click Care (PCC). They indicated that the identified residents’ weights had not been assessed or entered and that they were unsure why.

The Inspector reviewed the home's policy titled, "Section 11 Feeding and Hydration", date of origin August 2013, which stated that the PSW's are to weigh and record the residents weight monthly.

During an interview with the RD, they stated that the PSW's obtained the residents' weights and then the registered staff input the values into PCC. They stated that this should have been completed monthly for all residents. [s. 68. (2) (c)]

2. The licensee has failed to ensure that there was a weight monitoring system to measure and record with respect to each resident, (ii) body mass index and height upon admission and annually thereafter.

During stage one of the RQI, Inspector #612 identified 12 of the 40 residents in the census sample to have heights that were last recorded in more than two years previous.

During an interview with RPN #105, they stated that they were expected to obtain heights on admission and annually thereafter.

The Inspector reviewed the home's policy titled, "Section 11 Feeding and Hydration", date of origin August 2013, which stated that the PSW's were to record the residents' height on admission. There was no additional information regarding repeating the height annually.

During an interview with the Registered Dietitian, they stated that they only obtained heights once; they were unaware heights were required annually. [s. 68. (2) (e) (ii)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes

Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.

2. A change of 7.5 per cent of body weight, or more, over three months.

3. A change of 10 per cent of body weight, or more, over 6 months.

4. Any other weight change that compromises the resident’s health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status.

During a health care record review, Inspector #620 identified that resident #004 had experienced a significant weight change.

Inspector #620 reviewed resident #004's monthly weight recordings within the home's electronic documentation system. The review revealed that a significant weight change occurred over six months.

Inspector #620 reviewed resident #004's health care record and was unable to identify that a referral to the home's Dietitian had occurred in response to the resident's significant weight change. The Inspector was also unable to find evidence that indicated an assessment had occurred.

Inspector #620 interviewed the home's Dietitian who indicated that resident #004 had experienced significant weight change over 6 months. They indicated that as a result of the significant weight change an assessment should have been conducted. They stated that the assessment had not occurred as required. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Inspector #612 observed the controlled substance storage areas with RPN #105. RPN #105 stated that a controlled substance, was stored in a locked box, within the fridge. The RPN stated that the fridge was not locked, but that the door to the nurse's office remained locked, so the medication was double locked.

Inspector #612 reviewed the home's policy titled "The Medication Storage", policy number 3-4, last reviewed February 2017, which stated that, "narcotic and controlled (monitored) medication are to be locked (e.g in the cart) separated from other regular medications and locked in the medication room (Of note: in Ontario these medications are to be double locked in the cart or cabinet in a locked room – i.e. triple locked)."

Inspector #612 interviewed the DOC who stated that they were not aware that the controlled medications were required to be triple locked, but stated that they would add an additional lock on the fridge. [s. 129. (1) (b)]

Issued on this 2nd day of August, 2017

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

Original report signed by the inspector.

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) :	ALAIN PLANTE (620), MICHELLE BERARDI (679), SARAH CHARETTE (612)
Inspection No. / No de l'inspection :	2017_562620_0007
Log No. / Registre no:	005880-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 28, 2017
Licensee / Titulaire de permis :	WIKWEMIKONG NURSING HOME LIMITED 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0
LTC Home / Foyer de SLD :	WIKWEMIKONG NURSING HOME 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cheryl Osawabine-Peltier

To WIKWEMIKONG NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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,

a) ensure that residents are protected from abuse by anyone,

b) ensure that all incidents of suspected/actual abuse are immediately investigated, and

c) ensure that the home's newly evaluated, revised, and analyzed Policy on Zero Tolerance of Abuse and Neglect is complied with by all staff.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that all residents were protected from abuse by anyone.

Inspector #679 reviewed a complaint received by the Director. The complainant suspected that resident #011 had been sexually abused by a staff member in the home.

With regards to the allegation of sexual abuse toward resident #011 by staff, the Inspector was unable to identify any grounds to support that staff to resident abuse had occurred. However, there were grounds to support that an individual known to resident #011 had exhibited abusive actions upon resident #011 and other residents in the home.

Inspector #679 reviewed resident #011's electronic progress notes. The review of the electronic progress notes for resident #011 revealed the following related to suspicion of verbal, financial, and emotional abuse directed toward resident

#011 by an individual known to them:

- RPN #105 documented that an individual known to resident #011 had been witnessed verbally and financially abusing the resident; this caused the resident to cry. RPN #105 indicated that they advised the individual that their behaviour was upsetting resident #011, and could be upsetting other residents. RPN #105 indicated that they notified the ADOC of the incident and that they were directed to notify the police, and did so.

- RPN #105 documented that the police arrived at the home and had an individual known to resident #011 removed from the property.

- The DOC documented that a PSW reported to them that an individual known to resident #011 had been verbally aggressive toward resident #011, other resident's in the home and staff. The documentation indicated that the DOC and the Administrator spoke with both resident #011 and the individual regarding the verbally aggressive behaviour, and that during the conversation, the individual continued to use foul language and an aggressive tone with both the Administrator and the DOC.

- RN #104 documented that they observed resident #011 crying. When RN #104 asked about what had upset them, they indicated that they had been discussing financial issues with an individual known to them and the conversation had been upsetting.

- A complaint was brought forward to Residents' Council by resident #011. They indicated that an individual known to them did not feel welcome by others in the home. A progress note indicated that the Administrator and the DOC explained to resident #011 that the individual known to them posed a threat to both residents and staff with regards to their behavior, and both residents and staff felt threatened and afraid of this individual.

- The DOC documented that they had notified the Physician about the, "disruptive behaviour" being exhibited by an individual known to resident #011, and that resident #011 and the organization could benefit if a peace bond or a trespass notice were in place. The DOC then notified the police service and the Elder Abuse Coordinator regarding the suspected emotional, and financial abuse from the individual known to resident #011.

- The DOC documented that the police service had advised the home to issue a trespass notice and a peace bond to protect the residents and staff from the individual known to resident #011.

- RPN #105 documented that an individual known to resident #011 had entered the home following the issuance of a peace bond and no trespass order. They indicated that the police were notified and the individual was removed from the premises by two Officers. The progress note detailed that the individual had verbally abused another resident (resident# 017). The note also indicated that resident #011 had indicated that the individual was abusive and that they were taking their money.

According to the LTCHA, 2007, s. 23 (1), every alleged, suspected or witnessed incident of the following that the licensee knows of, or that was reported to the licensee, was immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action was taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with.
Non-compliance related to s. 23 (1), of the LTCHA, 2007, was identified; please refer to WN #11 contained within this report for further details.

According to the LTCHA, 2007, s 20 (1), Without in any way restricting the generality of the duty provided for in section 19, every licensee shall 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. Non-compliance related to s. 20 (1), of the LTCHA, 2007, was identified; refer to WN #10, contained within this report for further detail.

According to the LTCHA, 2007, s 24 (1), any person who had reasonable grounds to suspect that any of the following had occurred or may have occurred shall immediately report the suspicion and the information upon which it was based to the director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident. Non-compliance related to s. 24 (1), of the LTCHA, 2007, was identified; refer to WN #3-3, contained within this report for further detail.

According to O.Reg. 99. (b), every licensee of a long-term care home was to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences. Non-compliance related to O.Reg. 99. (b), was identified; refer to WN #5 contained within this report for further detail.

In conclusion, the licensee failed to ensure that the home's policy to promote zero tolerance of abuse was complied with, failed to investigate, failed to report suspected\alleged abuse to the Director, and failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was evaluated.

In an interview with Inspector #679 RN#105 identified that resident #011 communicated to them that an individual known to them was financially, verbally and emotionally abusive towards them, and that they were scared of them. RN #105 stated that they informed the DOC about the conversation.

In an interview with the DOC they confirmed that the home was aware of the instances of emotional and verbal abuse and that the home suspected financial abuse, stating "the abuse was very evident" but did not report any of the instances to the Director.

Non-compliance was previously identified under inspection #2015_283544_0023, with a CO being served September 11, 2015; inspection #2015_332575_0004, with a CO served on February 17, 2015; and inspection #2014_331595_0004, with a CO served July 28, 2014.

The decision to re-issue this compliance order was based on the scope which had the potential to impact the fewest number of residents, the severity which indicated actual harm or risk of actual harm, and the compliance history which despite previous non-compliance issued including three compliance orders, noncompliance continued with this section of the legislation. [s. 19. (1)] (679)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 07, 2017

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. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee shall,

ensure that any person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

a) Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

b) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

c) Unlawful conduct that resulted in harm or a risk of harm to a resident.

d) Misuse or misappropriation of a resident's money.

Grounds / Motifs :

1. Inspector #679 reviewed a complaint received by the Director. The complainant suspected that resident #011 had been sexually abused by a staff member in the home.

Inspector #620 reviewed resident #011's electronic progress notes and identified ten individual progress notes that were documented; the notes indicated that the ADOC, DOC, and the Administrator were aware of actual/suspected verbal, emotional, and financial abuse directed toward resident #011 by an individual known to them. There was also a documented incident of verbal abuse towards resident #017 by the individual. For further detailed information related to the incidences refer to WN#11 within this inspection report.

Inspector #679 reviewed the home's abuse policy titled "Section 3 Residents Rights and Safety: Abuse and Neglect Prevention Program", last revised June 2015, which indicated that "all staff and volunteers of the home were expected to fulfill their moral and legal obligation to report any incident or suspected incident of resident abuse". The policy then described that the Administrator was to notify the MOHLTC via CIS or via pager (after hours or holidays) of any incident of suspected/actual incident of abuse.

Inspector #679 reviewed the MOHLTC's Critical Incident Reporting System (CIS). The Inspector was unable to identify any indication that the home had submitted a report of alleged or suspected abuse to the Director for any of the incidences that were documented in the resident's progress notes.

In an interview with the DOC they confirmed that the home was aware of the instances of emotional and verbal abuse, as well as, the suspicion of financial abuse when they stated, “the abuse was very evident.” The DOC verified that they had not reported any of the instances of actual/suspected abuse to the Director. [s. 24. (1)] (679)

2. During a resident interview, resident #007 indicated to Inspector #679 that they had been treated roughly by staff. The resident also indicated that staff had yelled at them on occasion.

Inspector #620 immediately advised the home's DOC of the allegation of abuse that resident #007 had disclosed.

The DOC indicated that they began their investigation when they were notified by Inspector #620 of the allegation of abuse.

Inspector #620 reviewed the Critical Incident Reporting System to identify if the

home had immediately submitted a critical incident report related to the allegation of abuse. The Inspector was unable to identify that the home had submitted a CI report for the allegation that had been reported to them by Inspector #620.

Inspector #612 interviewed the DOC who stated that they had not submitted a CI report or notified the Director about the alleged incident of abuse that resident #007 had reported to Inspector #679 which was reported to them by Inspector #620. [s. 24. (1)]
(620)

3. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may have occurred immediately reported the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Resident #010 reported to Inspector #679 that about a year ago a staff member had treated them roughly. Inspector #620 immediately reported the information to the DOC.

Inspector #612 reviewed the Critical Incident reports submitted by the home and was unable to locate any CI reports filed relating to this allegation of rough treatment that was reported to the DOC by Inspector #620.

Inspector #612 interviewed the DOC who stated that they had not notified the Director about the alleged abuse which was reported to them by Inspector #620.

Inspector #612 reviewed the home's policy titled, "Abuse and Neglect Prevention Program", subsection 3.2, last revised June, 2015. The policy stated that upon becoming aware of an alleged act of abuse, the Administrator/Designate was to notify the Ministry of Health and Long-Term care immediately via Critical Incident Reporting System, or via pager (after hours or holiday). The policy also included a reference to Mandatory Reporting of Abuse or Neglect under section 24 of the LTCHA, 2007.

Inspector #612 reviewed a memo from the Director, sent to all Long-Term Care Homes, dated March 28, 2012, which stated that any person who had reasonable grounds to believe that a resident had been abused or neglected

must immediately report the suspicion to the Director under section 24 of the LTCHA, 2007.

Inspector #612 was provided with the investigation notes by the DOC. In the notes, the DOC stated that because of the lack of dates and times for the incident, a Critical Incident report could not be submitted as the allegation was a mandatory requirement for submission.

Non-compliance was previously identified under inspection #2016_395613_0003, with a VPC being served February 22, 2016; inspection # 2015_283544_0023, with a CO served on September 11, 2015; and inspection # 2015_332575_0004, with a CO served February 17, 2015; and inspection #2014_331595_0004, with a CO being served on July 28, 2014.

The decision to issue this compliance order was based on the scope which had the potential to impact more than the fewest number of residents, the severity which indicated actual harm or risk of actual harm, and the compliance history which despite previous non-compliance issued including three compliance orders and one VPC, non-compliance continued with this section of the legislation. [s. 24. (1)]
(612)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 07, 2017

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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.
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.
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.
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).

Order / Ordre :

The licensee shall ensure that following program is be evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

a) Falls Prevention Program, ensuring that the program is consistent with O. Reg. 79/10, s. 49.,

b) Skin and Wound Care Program, ensuring that the program is consistent with O. Reg. 79/10, s. 50.,

c) Continence Care and Bowel Management Program, ensuring that the program is consistent with O. Reg. 79/10, s. 51., and

d) Nutrition and Hydration Program, ensuring that the program is consistent with O. Reg. 79/10, s. 68., and 69.

Grounds / Motifs :

1. The licensee has 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 section 48 of the regulation; specifically, there was no written description of the program that included its goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

During stage one of the RQI, resident #002 and #009 were identified to have experienced a significant weight change. Upon review of resident #002's recorded weights in the home's electronic health record, Point Click Care (PCC), it was identified that they had experienced a significant weight change. Resident #009 had also experienced a significant weight change.

During an interview with Inspector #679, RPN #105 identified that if there was a discrepancy in the resident's weight, the PSWs were to complete a re-weigh. If there was a noted significant weight change after a re-weigh, then a referral was to be sent to the RD through PCC.

During an interview with Inspector #612, the RD stated that they were unaware of the significant weight change experienced by resident #002 and #009. They stated that the registered staff would input the weights into PCC and complete a

referral to the RD if there was a significant weight change through PCC. The RD stated that they had not received a referral.

The Inspector reviewed the home's policy titled, "Feeding and Hydration Program", subsection 11.1, date of origin August 13, 2017. Under the heading "Hydration Policy" the document described that the PSWs were to obtain the residents' weights on a monthly basis and re-weigh if there was a variance in the monthly weight of two kilograms or more. The policy did not address the referral process to the interdisciplinary team members, including criteria for a referral, and the process to complete a referral.

Inspector #612 interviewed the RD and confirmed that the home's Dietary Services and Hydration Program did not include a written descriptions of procedure for referral to the RD and to specialized resources. [s. 30. (1) 1.] (612)

2. The licensee has failed to ensure that the home's Skin and Wound Program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Non-compliance related to skin and wound care was identified for resident #003 (for details please refer to WN #19-2), and resident #008 (for details please refer to WN #1-1).

During a record review, Inspector #679 identified that the home's Skin and Wound Policy, titled, "Section 16: Wound and Skin Care Program" was dated August, 2013.

A review of the home's Skin and Wound policy identified that "The Wound and Skin Care Committee shall review the Wound and Skin Care Program annually to determine the effectiveness of the program and to identify changes to improve the program. The Wound and Skin Care Committee shall provide a written evaluation of the program annually to the Quality Management Committee."

During an interview with Inspector #679, the DOC identified that the home's Skin and Wound Care policy had not been updated annually, and that it was last updated in August, 2013. [s. 30. (1) 3.] (612)

3. The licensee has failed to ensure that the home's Falls Prevention and Management Program was evaluated and updated at least annually in

accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Non-compliance related to falls prevention and management was identified for resident #001 (for details please refer to WN #18), and resident #009 (for details refer to WN #1-4).

Inspector #612 reviewed the Falls Prevention Program as provided by the DOC and noted that the date of the last review was identified as June, 2015. The document titled, "Falls Prevention Program," subsection 3.6, stated that the Interdisciplinary Falls Team was to review the falls management program annually to determine the effectiveness of the program and to identify changes to improve the program. The team was also required to provide a written evaluation of the Falls Management Program annually to the Quality Management Committee.

On April 26, 2017, Inspector #612 interviewed the DOC who stated that the policy had not been reviewed annually and was last reviewed in 2015. [s. 30. (1) 3.] (612)

4. The licensee has failed to ensure that the home's Continence Improvement Program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Non-compliance related to continence was identified for resident #006 (for details please refer to WN #13-1), and resident #009 (for details please refer to WN #1-4 and WN #13-2).

During a record review, Inspector #679 identified that the home's Continence Improvement policy titled, "Section 12: Continence Care and Bowel Management Program" was last revised in December, 2015.

A review of the home's Continence Improvement policy identified that Registered Nursing Staff were required to, "Annually evaluate the program and the effectiveness of the continence care and bowel management. A written record will be kept of the program review and will include the name and relevant discipline of the individuals."

During an interview with inspector #679, the DOC confirmed that the home's Continence Improvement Policy had not been reviewed annually and that the last review was completed in December, 2015.

The decision to issue this compliance order was based on the scope which had the potential to impact a large number of the home's residents, the severity which indicated minimal harm or a potential for actual harm, and the compliance history, with a WN having been served to the home on February 17, 2015, under a similar potion of the legislation. [s. 30. (1) 3.] (679)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 28, 2017

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 99. Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Order / Ordre :

The licensee shall ensure,

(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it,

(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences,

(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation,

(d) that the changes and improvements under clause (b) are promptly implemented, and

(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

Grounds / Motifs :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

Non-compliance related to zero tolerance of abuse and neglect of residents was identified for resident #007 (for details please refer to WN #3-2), and resident #010 (for details please refer to WN #3-1), and resident #011 (for details please refer to WN #2, WN #3-3, and WN #11).

Inspector #612 reviewed the home's policy titled, "Abuse and Neglect Prevention Program", subsection 3.2 and noted that the last date revised was June 2015.

On April 26, 2017, Inspector #612 interviewed the DOC who stated that the policy had not been reviewed or evaluated since June 2015.

The decision to issue this compliance order was based on the scope which had the potential to impact a large number of the home's residents, the severity which indicated minimal harm or a potential for actual harm, and the compliance history with previous unrelated non-compliance having been issued to the home. [s. 99. (b)] (612)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 28, 2017

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan that ensures where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and if there are none, in accordance with prevailing practices, to minimize the risk to the resident ensuring steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

In all aspects of the development and implementation of the plan, the home is required to apply the guidance from the Ministry of Health and Long-Term Care memo dated August 21, 2012, which was sent to all Long-Term Care Home Administrators indicating that all LTC homes should use the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards' as a best practice document in their homes.

This plan shall include, but is not limited to:

a) A detailed description of how the licensee will ensure that where bed systems fail the zone entrapment testing, interventions are put in place immediately to eliminate the risk to the resident.

b) The plan shall also include specified time frames for the development and implementation and identify the staff member (s) responsible for the implementation.

The plan shall be submitted in writing to Alain Plante, Long Term Care Homes Inspector at 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5. Alternatively, the plan may be faxed to the Inspector's attention at (705) 564-3133.

The plan must be submitted by July 12, 2017, and be fully implemented by July 28, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

During stage one of the Resident Quality Inspection, Inspectors #679 and #612 identified four resident beds (#002, #003, #006 and #017) in which there was an approximately 20 centimeter gap between the mattress and the footboard or the mattress and the headboard of the bed.

In an interview with RPN #105, they stated that staff observe for entrapment zones once the mattress is put onto the bed frame. If there is any abnormalities then the mattress is changed. RPN #105 stated there was no formal process for assessing the entrapment zones.

In an interview with Inspector #679, the Maintenance Manager stated that the home did not conduct an assessment of each resident's bed system and potential zones of entrapment.

A review of the home's policy titled "Resident Services Manual: Section 3 Resident Safety" dated July 2012, outlined that the home was to establish an interdisciplinary group that would accept responsibility for measuring existing bed systems and taking corrective actions when indicated. The policy then identified that the home was to assess the beds within the home to ensure that entrapment zones and risks were identified.

A memo from the Ministry of Health and Long-Term Care (MOHLTC) dated August 21, 2012 was sent to all Long-Term Care (LTC) Home Administrators indicating that all LTC homes should use the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards' as a best practice document in their homes. This document referenced the 'Clinical Guidance for the Assessment and implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings' (CGA), as a prevailing practice for assessing the use of bed rails. The memo informed all LTC homes that they were required to conduct assessments for zones of entrapment; specifically but not limited to zone 7, the zone between the head or foot board and the end of the mattress.

In an interview with Inspector #679, the DOC confirmed that there was no assessment conducted by the home to assess each resident bed for entrapment zones.

The decision to issue this compliance order was based on the scope which had the potential to impact a largest number of the home's residents, the severity

which indicated minimal harm or a potential for actual harm, and the compliance history which despite previous non-compliance issued in a written notification in February 2015, during inspection #2015_332575_0004, non-compliance continued with this section of the legislation. [s. 15. (1) (a)] (620)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 28, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

À l'attention du registraire Commission d'appel et de révision des services de santé 151, rue Bloor Ouest, 9e étage Toronto (Ontario) M5S 2T5	Directeur a/s Coordinateur des appels Inspection de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Ontario, ON M5S-2B1 Fax: 416-327-7603

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

Issued on this 28th day of June, 2017

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Alain Plante

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