Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 19, 2015	2015_333577_0008	S-000770-15	Resident Quality Inspection

Licensee/Titulaire de permis

SIOUX LOOKOUT MENO-YA-WIN HEALTH CENTRE
Fifth Avenue South PO Box 909 SIOUX LOOKOUT ON P8T 1B4

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

WILLIAM A. "BILL" GEORGE EXTENDED CARE FACILITY
75 FIFTH AVENUE SIOUX LOOKOUT ON P8T 1K9

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

DEBBIE WARPULA (577), LINDSAY DYRDA (575)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 30-April 3, 2015 & April 6-10, 2015

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care (DOC), Registered Practical Nurses (RPN), Registered Dietitian (RD), Personal Support Workers (PSW), Dietary Worker, Activity Worker, Family Members and Residents

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home, observed staff to resident interactions, reviewed resident health care records and reviewed home policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Quality Improvement
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing
Trust Accounts

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

22 WN(s)
7 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with 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 that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Non-compliance had previously been identified related to bed rails: During an inspection completed June 2014 under inspection #2014_211106_0010, one Compliance Order was issued pursuant to O.Reg 79/10, s. 15. (1) (a) the licensee failed to ensure that 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 risk to the resident.

Inspector #575 reviewed the health care records for resident #012, #014, and #015. The inspector noted that all three residents had a bed rail assessment completed using the home's form titled 'A Guide to Assist with the Decision Regarding the Use of Side Rails and Alternate Assistive Devices'.

The inspector interviewed the DOC regarding bed rails and bed system assessments. The DOC stated that residents are assessed for bed rails using the home's guide (as indicated above) and that the home had purchased the tools to assess the beds for entrapment and that all beds are purchased with mattresses to fit the bed. The DOC stated that the tools were recently bought and they are looking at training a staff member to assess the beds. To date, no beds have been assessed however they hope within the next 3 months that the beds will be assessed.

The inspector asked the DOC for a record of residents and their type of bed system. The DOC checked all of the beds and made corrections to the record. The record indicated that resident #012 and #015 had a specific type of bed and mattress, however, the inspector observed both bed systems and noted that both residents had a different type of mattress than indicated in the record, therefore the record was inaccurate. [s. 15. (1) (a)]

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 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 there is a Continence Care and Bowel Management Program that has 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.

On April 7, 2015, Inspector #577 met with DOC regarding the Continence Care and Bowel Management Program. They reported that the program is in draft form and is not currently implemented in the home. It was further reported that staff use a Bladder and Bowel Continence Assessment on admission and complete a quarterly assessment.

A previous Compliance Order was issued August 20, 2014, log #S-000210-14, #2014_211106_0010 with a compliance date of September 30, 2014.

Compliance Order #001 that was issued on August 20, 2014, ordered the licensee to do the following:
"The licensee shall ensure that the organized program required under section 48 of the Regulation, specifically the Continence Care and Bowel Management Program, that there is a written description of the program that includes its goals and objectives, relevant policies, procedures, and protocols, methods to reduce risk, outcomes monitoring, and protocols for referral of residents to specialized resources where required". [s. 30. (1) 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #012.

Inspector #575 observed resident #012 to have a health condition that required a positioning device. S#102 confirmed that the resident had a health condition, that physio is involved in the residents care, and that staff used a specific item for positioning. The inspector noted that the intervention of the use of this item for positioning for the resident's health condition was not indicated in the resident's written plan of care. The inspector asked s#102 how they knew to do that and s#102 stated that a staff member started doing it, therefore all other staff started to do it. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #015.

Inspector #575 reviewed resident #015's health care record. The inspector noted that the resident received special daily nutrition . The resident's care plan was reviewed on April 1, 2015 and indicated the resident received this nutrition at 1000hr and 1300hr. The

residents most recent Nutritional Reassessment form completed by the Dietitian indicated 1000hr and 300hr.

The inspector noted that a similar finding was issued during the previous RQI inspection (#2014_211106_0010) regarding the same resident. The care plan was not updated to reflect the most recent Dietitian recommendations. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #004.

On April 9, 2015, Inspector #577 reviewed resident #004's care plan related to feeding. The care plan indicated that resident required specific feeding precautions. Under another focus, the care plan indicated that resident feeds self independently but requires assistance.

Inspector #577 reviewed the Registered Dietitian's reassessment forms dated January 2015, which indicates that resident #004 requires assistance with eating. Inspector reviewed the RAI-MDS for time period February 2015, which indicated that resident is dependent on staff for eating.

On April 10, 2015, Inspector spoke with s#101 and DOC, who both reported that resident does not feed themself, and is dependent on staff to feed them all their meals. [s. 6. (1) (c)]

4. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #005.

On March 31, 2015, during a stage one family interview, resident #005's POA reported the resident's oral status and their preferences related to their oral status.

On April 2, 2015, Inspector #577 reviewed resident #005's plan of care related to oral hygiene. The plan of care indicated the resident's oral status, preferences and that staff are to monitor their oral health status. Reviewed resident's oral assessment completed on March 2015. The assessment indicated the resident's oral status and preferences in regards to their oral status. Reviewed the oral hygiene care plan completed on March 2015, which indicated the resident's oral status, tools to be used for oral care, when oral care is to be completed and barriers the resident has to oral care. Care plan did not indicate the level of assistance required by resident #005.

Inspector #577 interviewed s#103 regarding resident #005's oral hygiene. They reported the resident's oral status and the tools they use for oral care for resident #005, the tools they indicated were different than the tools listed in the plan of care. S#104 further reported the resident's oral status and how they assist resident #005 with oral care, which was also different than what was specified in the plan of care.

Resident #005's care plan does not include documented interventions that resident requires to maintain their oral hygiene. [s. 6. (1) (c)]

5. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan.

During the inspection, Inspector #577 noted that resident #002 was incontinent. During record review of care plan related to toileting, it indicated that resident is incontinent and staff are to follow a toileting schedule to assist with continence.

The inspector observed another day during the inspection between 0830hr and 1630hr, that staff were not following the toileting schedule, as per care plan directions. [s. 6. (7)]

6. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #012 as specified in the plan.

Inspector #575 reviewed resident #012's health care record. According to the most recent RAI-MDS assessment, the resident had altered skin integrity. The physician order indicated the resident was to receive a specific treatment. The inspector confirmed with s#102 that the treatment was to be completed at least every two days and more often if needed.

During an interview, the DOC stated that the treatment could be documented in the progress notes or in another report. The inspector reviewed the resident's wound record of the treatment for a period of one month. The inspector noted the treatment was not completed as ordered on four occasions during the month that was reviewed:

Treatment was completed and then not completed for 3 days.
Treatment was completed and then not completed for 5 days.
Treatment was completed and then not completed for 3 days.
Treatment was completed and then not completed for 3 days.

The resident's progress notes were reviewed by the inspector and there were no notes that indicated any additional treatments completed.

The home's policy titled 'Assessment and Care of Skin and Pressure Wounds/Ulcers' last approved 03/09/2015, indicated that residents are to be assessed and documented daily or with every dressing change on the wound assessment tool (wound record). [s. 6. (7)]

7. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

On April 1, 2015, Inspector #577 reviewed resident #003's plan of care, which indicated that staff are to monitor and record output.

Inspector #577 reviewed the output sheets for resident #003 for February and March 2015. Inspector noted that the output was not recorded on the following day shifts: February 1, 6, 8-10, 12, 13, 15, 17, 19, 24-28, 2015, and March 1, 4, 8, 9, 13, 15, 16, 22, 24, 25, 29 & 31, 2015. [s. 6. (7)]

8. The licensee has failed to ensure that plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Inspector #575 reviewed resident #012's health care record. The resident's care plan indicated under a specific heading that the resident was to have a treatment completed every two days, however on the same care plan, under a different heading it indicated that the treatment was to be completed Monday, Wednesday and Friday.

The current physician orders indicated the treatment was to be completed every two days. During an interview, s#102 stated that the resident had treatment for months however they do not currently require this treatment.

The resident's care plan was not updated when the resident no longer required the treatment. [s. 6. (10) (b)]

9. The licensee has failed to ensure that plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

On April 7, 2015, Inspector #577 conducted a record review of resident #002's care plan related to continence. The care plan indicated that resident is independent with continence but was frequently incontinent.

Inspector reviewed 2 separate continence assessments which indicated a significant change and the care plan did not reflect this change. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care for residents #002, #003, #004, #005, #012 & #015, and every other resident, sets out clear directions to staff and others who provide direct care; to ensure that the care set out in the plan of care is provided to all residents, and specifically residents #003 & #012, as specified in the plan; and to ensure the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary for every resident, and specifically residents #002 and #012, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy 'Residents' Weight and

Heights in Long Term Care' is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Inspector #575 reviewed resident #012's health care record. The inspector noted that from October 2014 to January 2015, the resident had a 7.9% change of body weight over three months.

The inspector interviewed s#104 regarding resident weights. S#104 stated that if a resident has a weight change of plus or minus 3 kgs, they will notify registered staff when documenting the weight in the resident's chart. A registered staff member stated to the inspector that they would notify the DOC and the Dietitian of a resident weight change of 2 lbs or 2 kgs in one month. The staff member further stated that they do not review resident's weights over three months or six months and only review month by month.

The inspector reviewed the home's policy titled 'Residents' Weight and Heights in Long Term Care' effective October 2014, and approved February 26, 2015. The policy only indicated that registered staff 'documenting the weight shall compare it to previous weights and notify the registered dietitian and the multidisciplinary team of weight change of 5% or more'. The policy did not provide for the requirements under O.Reg.79/10, s.69. (2) regarding a 7.5% weight change or more, over three months, a 10% weight change or more, over six months, or any other weight change that compromises their health. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with.

On April 1, 2015, Inspector #577 determined through record review, that resident #004 had a 5.6 % weight loss between February and March 2015.

On April 8, 2015, Inspector reviewed home's policy "Residents' Weights and Heights in Long Term Care" LTC.2.100, approval date February 26, 2015. Policy indicates that 'the Registered Practical Nurse documenting the weight shall compare it to previous weights and notify the registered dietitian and the multidisciplinary team of weight change of 5 % or more'.

Inspector spoke with Registered Dietitian on April 8, 2015, concerning resident #004's weight change. They reported that the last assessment they completed was on January 15, 2015. It was further reported that they try to see all the residents every month, and did not receive a referral, nor was notified about resident #004's weight change. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee has failed to ensure that the 'Policy of Least Restraint' is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Inspector #575 reviewed the home's policy titled 'Policy of Least Restraint' last approved 06/07/2013, and noted that the policy indicated that the potential for removal of the restraint and use of alternatives must be assessed at least once every 12 hours by the nurse and physician. Pursuant to O.Reg 79/10, s. 110. (2). 6., that the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

The policy indicated reassessment every 12 hours, however, resident's are required to be reassessed every eight hours. [s. 8. (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 to ensure that the home's policy 'Residents' Weight and Heights in Long Term Care' and the 'Policy of Least Restraint' is in compliance with and is implemented in accordance with all applicable requirements under the Act, specifically in regards to residents #004 & #012, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, (c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required.

On March 31, 2015, during a stage one family interview, resident #005's POA reported the resident's oral status.

On April 2, 2015, Inspector #577 reviewed resident #005's health care record and documentation of an offer of an annual dental assessment was not found.

On April 1, 2015, during a stage one family interview, resident #014's POA reported the resident's oral status and concerns regarding the resident's dental status.

On April 2, 2015, Inspector #577 reviewed resident #014's health care record and documentation of an offer of an annual dental assessment was not found.

Inspector #577 spoke with DOC on April 8, 2015 and asked whether the home offers residents an annual dental assessment and other preventative dental services, subject to payment being authorized by the resident or the SDM if payment is required. The DOC reported that annual dental assessments aren't offered to residents in the home. [s. 34. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, (c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required, specifically in regards to residents #005 & #014, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour program is developed and implemented in accordance with evidence-based practices or, if there are none, prevailing practices.

During an interview, the DOC stated to inspector #575 that the home does not currently have written approaches regarding responsive behaviours as required. The DOC stated that staff are trained in Gentle Persuasive Approach (GPA) and staff can utilize the psychogeriatric resource program, however, the home does not have any procedures in writing regarding screening protocols, assessments or reassessments.

A previous non-compliance was issued during an inspection conducted in June 2014 (inspection #2014_211106_0010) requesting the home to prepare a written plan of correction for achieving compliance to ensure that a responsive behaviour program was developed and implemented. [s. 53. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a Responsive Behaviour Program is developed and implemented in accordance with evidence-based practices, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

Residents' Council meeting minutes from January 2014, to February 2015, were reviewed by inspector #575. During the January 9, 2014 meeting, the resident satisfaction survey was reviewed for input and approval. The survey was also sent to families on January 15, 2014, for suggestions. The March 24, 2014, meeting minutes indicated that the survey would be available in the next few months.

During an interview, the DOC stated that the resident satisfaction survey was not completed in 2014, and the survey was only sent out on March 20, 2015 (over one year after seeking input and approval by the Residents' Council). [s. 85. (1)]

2. The licensee has failed to ensure that at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

On April 9, 2015, Inspector #577 reviewed the completed, "LTCH Licensee Confirmation Checklist - Quality Improvement". Inspector interviewed DOC to determine if an annual satisfaction survey was being taken of residents and families. During the interview, DOC reported that an annual survey was not done for year 2014, and wasn't sure when surveys had been sent out before. It was further reported that they have sent out surveys for 2015, in March of this year, dated March 15, 2015. [s. 85. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
4. Consent. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

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

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the documentation included consent for the use of the physical device to restrain.

On March 31, 2015, Inspector #575 observed resident #015 in bed with bed rails up. The inspector reviewed the resident's health care record. The resident's care plan identified that the resident required staff assistance with bed mobility. The care plan also indicated that staff are to ensure that both bed rails are up when the resident is in bed. 'A Guide to Assist with the Decision Regarding the Use of Side Rails and Alternate Assistive Devices'

dated October 3, 2014, stated that the resident had used bed rails.

The home's policy titled 'Policy of Least Restraint' approved 06/07/2013, indicated that the 'LTC side-rail consent' is to be completed for routine use of bed rails. During an interview, the DOC stated that resident #015 did not have a signed consent form. [s. 110. (7) 4.]

2. The licensee has failed to ensure that the documentation included consent for the use of the physical device to restrain.

On March 31, 2015, Inspector #575 observed resident #012 in bed with bed rails up. The inspector reviewed the resident's care plan. Under the heading 'Physical Restraints', the care plan indicated that bed rails are to be up as per physician orders. 'A Guide to Assist with the Decision Regarding the Use of Side Rails and Alternate Assistive Devices' dated October 6, 2014, stated that the resident had used bed rails.

The home's policy titled 'Policy of Least Restraint' approved 06/07/2013, indicated that the 'LTC side-rail consent' is to be completed for routine use of bed rails. During an interview, the DOC stated that resident #012 did not have a signed consent form. [s. 110. (7) 4.]

3. The licensee has failed to ensure that the documentation included the person who applied the device and the time of application.

Inspector #575 reviewed resident #015's health care record. The resident required the use of bed rails. During an interview, the DOC stated that when bed rails are used, the resident should be checked hourly using the restraint flow sheet. In addition, s#102 stated that PSWs apply restraints, however the RPNs document on the restraint flow sheet and hourly checks are documented on a clipboard in each resident's room.

The inspector reviewed the restraint record for resident #015 for March 2015, and noted that the record did not include who applied the device. The only documentation included is the decision to apply by the registered staff and the inspector noted it was only documented 13/31 days. [s. 110. (7) 5.]

4. The licensee has failed to ensure that the documentation included the person who applied the device and the time of application.

Inspector #575 reviewed resident #012's health care record. The resident required the use of bed rails. During an interview, the DOC stated that when bed rails are used, the resident should be checked hourly using the restraint flow sheet. In addition, s#102 stated that PSWs apply restraints, however the RPNs document on the restraint flow sheet and hourly checks are documented on a clipboard in each resident's room.

The inspector reviewed the restraint record for resident #012 for March 2015, and noted that the record did not include who applied the device. The only documentation included is the decision to apply by the registered staff and the inspector noted it was only documented 11/31 days. [s. 110. (7) 5.]

5. The licensee has failed to ensure that the documentation included all assessment, reassessment and monitoring, including the resident's response.

Inspector #575 reviewed resident #015's health care record. The resident required the use of bed rails. During an interview, the DOC stated that when bed rails are used, the resident should be checked hourly using the restraint flow sheet. In addition, s#102 stated that PSWs apply restraints, however the RPNs document on the restraint flow sheet and hourly checks are documented on a clipboard in each resident's room.

The home's policy titled 'Policy of Least Restraint' indicated that staff are required to document hourly monitoring and assessments on the restraint flow sheet.

The inspector reviewed resident #015's restraint flow sheet for March 2015. The inspector noted that the documentation did not include hourly monitoring, any assessments, the resident's response, and the reassessments were only documented on 12/31 days. Additionally, the reassessments were only indicated daily and not every 8 hours as required. [s. 110. (7) 6.]

6. The licensee has failed to ensure that the documentation included all assessment, reassessment and monitoring, including the resident's response.

Inspector #575 reviewed resident #012's health care record. The resident required the use of bed rails. During an interview, the DOC stated that when bed rails are used, the resident should be checked hourly using the restraint flow sheet. In addition, s#102 stated that PSWs apply restraints, however the RPNs document on the restraint flow sheet and hourly checks are documented on a clipboard in each resident's room.

The home's policy titled 'Policy of Least Restraint' indicated that staff are required to document hourly monitoring and assessments on the restraint flow sheet.

The inspector reviewed resident #012's restraint flow sheet for March 2015. The inspector noted that the documentation did not include hourly monitoring, any assessments, the resident's response, and the reassessments were only documented on 12/31 days. Additionally, the reassessments were only indicated daily and not every 8 hours as required. [s. 110. (7) 6.]

7. The licensee has failed to ensure that the documentation included every release of the device and repositioning.

Inspector #575 reviewed resident #015's health care record. The resident required the use of bed rails. During an interview, the DOC stated that when bed rails are used, the resident should be checked hourly using the restraint flow sheet. In addition, s#102 stated that PSWs apply restraints, however the RPNs document on the restraint flow sheet and hourly checks are documented on a clipboard in each resident's room.

The inspector reviewed resident #015's restraint record for March 2015. The inspector noted that only one application and removal was documented on 14/31 days, on 2/31 days only transfers were documented. The documentation only provided for indicating repositioning every 4 hours and was not complete. The documentation did not provide for every release of the device and repositioning. [s. 110. (7) 7.]

8. The licensee has failed to ensure that the documentation included every release of the device and repositioning.

Inspector #575 reviewed resident #012's health care record. The resident required the use of bed rails. During an interview, the DOC stated that when bed rails are used, the resident should be checked hourly using the restraint flow sheet. In addition, s#102 stated that PSWs apply restraints, however the RPNs document on the restraint flow sheet and hourly checks are documented on a clipboard in each resident's room.

The inspector reviewed resident #012's restraint record for March 2015. The inspector noted that on March 2, 3, 4, 2015, only the application of the device was documented, March 27, 2015, only the removal of the device was documented, March 31, 2015, only transfers were documented; March 24, 2015, indicated application and removal. The documentation only provided for indicating repositioning every 4 hours and was not

complete. The documentation did not provide for every release of the device and repositioning. [s. 110. (7) 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 to ensure there is documentation on consent with every use of a physical device to restrain a resident, the person who applied the device and the time of application is documented; assessment, reassessment and monitoring, including the residents response is documented, and documentation of every release of the device and all repositioning, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following:

s. 241. (1) Every licensee of a long-term care home shall establish and maintain at least one non-interest bearing trust account at a financial institution in which the licensee shall deposit all money entrusted to the licensee’s care on behalf of a resident. O. Reg. 79/10, s. 241 (1).

s. 241. (4) No licensee shall,
(a) hold more than $5,000 in a trust account for any resident at any time; O. Reg. 79/10, s. 241 (4).
(b) commingle resident funds held in trust with any other funds held by the licensee; or O. Reg. 79/10, s. 241 (4).
(c) charge a resident, or a person acting on behalf of a resident, a transaction fee for withdrawals, deposits, or anything else related to money held in trust. O. Reg. 79/10, s. 241 (4).

s. 241. (7) The licensee shall,
(a) provide a resident, or a person acting on behalf of a resident, with a written receipt for all money received by the licensee from the resident, or any other person, for deposit in a trust account on behalf of the resident; O. Reg. 79/10, s. 241 (7).

s. 241. (7) The licensee shall,
(d) maintain a separate book of account for each resident for whom money is deposited in a trust account; O. Reg. 79/10, s. 241 (7).

s. 241. (7) The licensee shall,
(f) provide to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident’s funds as of the date of the statement; and O. Reg. 79/10, s. 241 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that they establish and maintain at least one non-interest bearing trust account at a financial institution in which the licensee shall deposit all money entrusted to the licensee’s care on behalf of a resident. O. Reg. 79/10, s. 241 (1).

On April 9, 2015, Inspector #577 spoke with s#109 who reported that there was only one resident with a trust account in the home. Inspector spoke with DOC, who further reported that the home keeps a petty cash safe to store resident money in. Inspector reviewed a binder labelled, 'Resident Bank Accounts' and found records for 10 residents with money locked in the safe. These records also contained a receipt book of recorded deposits and withdrawals. [s. 241. (1)]

2. The licensee has failed to ensure that (4) No licensee shall, (a) hold more than $5,000 in a trust account for any resident at any time;
(O. Reg. 79/10, s. 241 (4).

On April 9, 2015, Inspector #577 spoke with s#109, who reported that a specific resident has a trust account balance of greater than $5,000 [s. 241. (4) (a)]

3. The licensee has failed to ensure that they have, (a) provided a resident, or a person acting on behalf of a resident, with a written receipt for all money received by the licensee from the resident, or any other person, for deposit in a trust account on behalf of the resident; O. Reg. 79/10, s. 241 (7).

During a stage one family interview, a family member reported to Inspector #577 that they are unsure if they receive a monthly statement for the money that the home in trust has to ensure that day to day incidentals are paid for.

On April 7, 2015, Inspector #577 asked s#109 if residents and families are provided with a monthly statement of the money held in trust. They reported that there was only one resident with a trust account and that resident has not received any written receipts when there have deposits or withdrawals. [s. 241. (7) (a)]

4. The licensee has failed to ensure that they have (d) maintained a separate book of account for each resident for whom money is deposited in a trust account; O. Reg. 79/10, s. 241 (7).

On April 7, 2015, Inspector #577 asked s#109 whether they maintain a separate book of account for each resident for whom money is deposited in a trust account. They reported that there was only one resident with a trust account in the home. They further reported that they do not maintain a separate account book for each resident for whom money is deposited into a trust account. [s. 241. (7) (d)]

5. The licensee has failed to ensure that they (f) provided to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement; and O. Reg. 79/10, s. 241 (7).

On April 7, 2015, Inspector #577 asked s#109 if residents and families are provided with a monthly statement of the money held in trust. They reported that there was only one resident with a trust account and quarterly itemized statements have not been provided to resident. [s. 241. (7) (f)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that one non-interest bearing trust account at a financial institution in which the licensee shall deposit all money entrusted to the licensee's care on behalf of a resident; hold no more than $5,000 in a trust account for any resident at any time, ensure that they have, (a) provided a resident, or a person acting on behalf of a resident, with a written receipt for all money received by the licensee from the resident, or any other person, for deposit in a trust account on behalf of the resident; ensure that they have (d) maintained a separate book of account for each resident for whom money is deposited in a trust account; and to ensure that they (f) provided to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement, to be implemented voluntarily.

WN #10: 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 is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

On April 9, 2015, Inspector #577 met with DOC regarding staffing. It was reported that their staffing for a day shift consists of two registered practical nurses and three personal support workers, an evening shift consists of one RPN and three PSW's from 1530-1930hr, one RPN and one PSW from 1930-2330hr, and nights is staffed with one RPN and one PSW. They reported that weekends are staffed with one RPN per shift and PSW staffing complements are the same as during the week. It was further reported that they do not have a written staffing plan and when needed, they will pull from the casual pool and acute care. [s. 31. (2)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents’ families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) on an ongoing basis advise residents’ families and persons of importance to residents of the right to establish a Family Council; and (b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

On April 2, 2015, Inspector #577 spoke with s#107 regarding Family Council. They reported that the home does not have a family council and that a notice is posted twice a year to inform families of their right to establish a council. Inspector interviewed s#105, who further reported that they do not convene semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council. They further reported that they have posted information in a newsletter once and family council information is written in the admission package. [s. 59. (7) (a)]

WN #12: 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 there is a weight monitoring system to measure and record each resident's weight on admission and monthly thereafter.

During an interview, the DOC stated that the process for documenting resident weights is that staff write the resident's weight on their paper vital signs form in their chart and the RAI coordinator transcribes the weights online in Medecare. S#102 stated to the inspector that weights are recorded on a paper sheet initially, and then they would enter the weight into Medecare. S#102 was not sure if they were to transcribe to the paper vital sign sheet in each resident's chart.

Inspector #575 conducted an audit of ten residents' health care records. The inspector reviewed records of resident weights from October 2014 to March 2015. The inspector noted that in December 2015, 6/10 resident's weights were not recorded, admission weights were not recorded for 2/10 residents, and in February 2015, 1/10 resident's weights was missing. The inspector also noted that two residents had weights that were not recorded on the paper vital sign sheets, however the weight was recorded in Medecare. Additionally, the inspector noted a discrepency for a weight entered in March for one resident.

During an interview, s#100 indicated that they document resident weights by reviewing a 'cheat sheet' the staff use to first record resident weights. S#100 stated to the inspector that the documentation of resident weights is not consistent.

The home's policy titled ''Residents' Weights and Heights in Long-Term Care' stated that the admission and monthly weights should be documented on the vital sign flow sheet and in the resident's file on Medecare. [s. 68. (2) (e) (i)]

2. The licensee has failed to ensure that there is a weight monitoring system to measure and record each resident's body mass index and height on admission and annually thereafter.

During an interview, the DOC stated that residents' heights are recorded once per year and are documented in the resident's paper chart on the vital sign sheet.

Inspector #575 conducted a review of six residents' health care records with admission dates from 2007 to 2013. The inspector noted that all six residents only had their height recorded on admission.

During an interview, s#104 stated that resident heights are only taken on admission and are not done annually. S#102 stated that resident heights are completed once per year however they were not sure where it was recorded. S#100 stated to the inspector that resident heights are done annually and should be recorded on the vital sheet.

The inspector reviewed all vital sheets for each resident and noted that the sheet did not provide for an area to record an annual height. [s. 68. (2) (e) (ii)]

WN #13: 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 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 their health status.

Inspector #575 reviewed resident #012's health care record. The inspector noted that from October 2014 to January 2015, the resident had a 7.9% change of body weight over three months.

The inspector reviewed the resident's nutrition assessment forms dated October 16,

2014, November 20, 2014, and January 22, 2015. The inspector noted that the resident's weight was not recorded on the October 16, 2014, assessment form. The November 20, 2014, assessment form indicated the resident had a 1.5% weight change. The January 22, 2015, assessment indicated the resident's current weight and did not indicate the 7.9% weight change over 3 months (October 2014 to January 2015). The November and January assessments indicated that the resident's weight was stable.

During an interview, s#100 stated that they did not receive a referral for the 7.9% weight change over three months.

The inspector interviewed s#104 regarding resident weights. S#104 stated that if a resident has a weight change of plus or minus 3 kgs, they will notify registered staff when documenting the weight in the resident's chart. S#102 stated to the inspector that they would notify the DOC and the Dietitian of a resident weight change of 2 lbs or 2 kgs in one month. S#102 further stated that they do not review residents' weights over three months or six months and only review month by month.

The inspector reviewed the home's policy titled 'Residents' Weight and Heights in Long Term Care' effective October 2014 and approved February 26, 2015. The policy only indicated that registered staff 'documenting the weight shall compare it to previous weights and notify the registered dietitian and the multidisciplinary team of weight change of 5% or more'. The policy did not provide for procedures in the event of a 7.5% weight change over three months, 10% over six months, or any other weight change that compromises their health. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. The licensee has failed to 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 . O. Reg. 79/10, s. 69. r. 69.

On April 1, 2015, Inspector #577 determined through record review, that resident #004 had a 5.6 % weight change between February and March 2015.

Inspector spoke with s#100 on April 8, 2015, concerning resident #004's weight change. It was reported that the last assessment they completed for resident #004 was in January 2015, and they try to see all the residents every month.

On April 9, 2015, Inspector #577 reviewed the RD reassessment for resident #004 dated

January 2015. Resident was prescribed nutritional supplements with meals.

Resident #004 was not reassessed following a significant weight change, as confirmed by s#100. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On March 30, 2015, during a dining observation, Inspector #577 noted that weekly menus aren't posted in the dining area or any where in the home for residents. Inspector observed a black board with the daily menu posted. Inspector spoke with s#108, who confirmed that weekly menus aren't posted, and are kept in a black binder in the dining area. It was further reported by s#110 that weekly menu's aren't communicated to residents unless the resident specifically asks. [s. 73. (1) 1.]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents’ Bill of Rights; 2007, c. 8, s. 78 (2)

(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is

no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The licensee has failed to ensure that the admission package of information includes, at a minimum, (g) notification of the long-term care home’s policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)

On March 30, 2015, the home's DOC provided Inspector #577 with a copy of the home's admission package and the completed, MOHLTC, "LTCH Licensee Confirmation Checklist - Admission Process" document.

On April 9, 2015, the inspector interviewed the DOC to determine if the admission package included notification of the home's policy to minimize the restraining of residents and how to receive a copy. The DOC confirmed that the admission package did not contain information regarding restraints in the home. [s. 78. (2) (g)]

2. The licensee has failed to ensure that the admission package of information shall include, at a minimum, (n) a disclosure of any non-arm’s length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)

On April 9, 2015, inspector interviewed the DOC to determine if the admission package included a disclosure of any non-arm's length relationships that exist between the licensee and other providers who offer care, services, programs or goods to residents. The DOC confirmed that the admission package did not include information regarding disclosure of any non-arm's length relationships that exist between the licensee and other providers who offer care, services, programs or goods to residents. [s. 78. (2) (n)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) procedures are developed and implemented to ensure that, (iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

On April 1, 2015, resident #011 reported to Inspector #575, that some of their personal bedding and blankets had gone missing in January 2015.

Inspector #577 spoke with DOC on April 7, 2015, who reported that residents laundry is cleaned at the acute care site, and when an item is missing, staff will call the laundry department. They further reported that there isn't a specific policy for missing laundry nor a documentation form. [s. 89. (1) (a) (iv)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy addressed the duties and responsibilities of the staff, including who has the authority to apply or release a physical device.

During an interview, s#102 stated that PSWs apply restraints, however the RPNs are the ones who document. Inspector #575 reviewed the home's policy titled 'Policy of Least Restraint' approved 06/07/2013, and noted that the policy did not include the duties and responsibilities of the staff, including who had the authority to apply or release a physical device. [s. 109. (b) (i)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that in regards to the restraining of residents, the licensee keeps a written record, that is promptly prepared of: the monthly analysis, the annual evaluation and the changes and improvements required; the date of the annual evaluation; the names of the persons who participated in the evaluation; and the date that the changes were implemented.

During an interview, the DOC stated to inspector #577 that the home reviewed the restraining of residents on a monthly basis and review annually however they did not have a written record of such. [s. 113. (e)]

WN #19: 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 drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies and that is secure and locked.

Inspector #575 interviewed the DOC who stated that medications were stored in the medication room that is only accessible to registered staff and that the Government supply of fleet enemas and suppositories were stored in the clean utility room that is accessible to all staff. The inspector observed the supply of fleet enemas and suppositories in the clean utility room and observed a member of the housekeeping staff present in the room.

Additionally, during a medication administration on April 8, 2015, the inspector noted s#102 lock the medication cart by turning a handle. The inspector noted that the handle could be turned by anyone and the medication cart opened. The inspector asked s#102 if the cart was equipped to be locked with a key. S#102 stated that they thought so, but that they did not have a key on them.

On April 9, 2015, the inspector observed s#102 administer medications during the dinner service. The medication cart remained outside of the dining room and s#102 went into the room to administer medications. The inspector approached the medication cart and was able to open the cart; the medication cart was not locked. [s. 129. (1) (a)]

2. The licensee has failed to ensure that 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.

Inspector #575 conducted an observation of the home's medication storage area and medication cart. The inspector noted an open bottle of liquid medication on the counter in the medication room. The inspector also noted some controlled substances stored in a separate locked box in the stationary cupboard, however the stationary cupboard was not locked. S#102 stated that although the cupboard is equipped with a lock, it is never locked and they did not have a key.
Additionally, the inspector observed the medication cart and noted a controlled substance not locked in a separate area within the locked medication cart. The inspector noted the medication cart did not contain a separate locked area. [s. 129. (1) (b)]

WN #20: 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 all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

During an interview, the DOC stated to inspector #575 that drugs are stored in the medication room, however the home's Government stock of fleet enemas and suppositories are stored in the clean utility room. The DOC stated that the room is locked however all staff have access to the clean utility room.

The inspector observed the clean utility room and noted fleet enemas and suppositories. A housekeeping staff member was also observed accessing the room. [s. 130. 2.]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
1. The resident's ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1). O. Reg. 79/10, s. 224 (1).

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
7. The resident's ability to have money deposited in a trust account under section 241 of this Regulation. O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the admission package of information provided for in section 78 of the Act includes information about the following: 1. The resident's ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1). O. Reg. 79/10, s. 224 (1).

On April 10, 2015, Inspector #577 interviewed the DOC to determine if the admission package included information on the ability to retain a physician or RN (EC) to perform required services. The DOC confirmed that the admission package did not include information regarding the ability for residents to retain a physician or RN (EC) to perform the required services. [s. 224. (1) 1.]

2. The licensee has failed to ensure that the admission package of information provided for in section 78 of the Act includes information about the following: 7. The resident's ability to have money deposited in a trust account under section 241 of this Regulation. O. Reg. 79/10, s. 224 (1).

On April 9, 2015, Inspector #577 interviewed the DOC to determine if the admission package included information about the resident's ability to have money deposited in a trust account. The DOC confirmed that the admission package did not contain information on trust accounts. [s. 224. (1) 7.]

WN #22: 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. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Inspector #575 reviewed Resident #012's health care record. According to the RAI-MDS assessment dated December 2014, the resident had an infection. During an interview, the DOC stated that symptoms of infection should be recorded each shift in the resident's progress notes. The inspector reviewed the resident's progress notes and noted that on a day in December 2014, staff noticed the resident to be unwell during the night shift. The resident was then assessed that day by the Nurse Practitioner and was ordered antibiotics. The inspector noted that the next progress note was not recorded until 2 days later. [s. 229. (5) (a)]

Issued on this 26th day of August, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBBIE WARPULA (577), LINDSAY DYRDA (575)
Inspection No. / No de l'inspection :	2015_333577_0008
Log No. / Registre no:	S-000770-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 19, 2015
Licensee / Titulaire de permis :	SIOUX LOOKOUT MENO-YA-WIN HEALTH CENTRE Fifth Avenue South, PO Box 909, SIOUX LOOKOUT, ON, P8T-1B4
LTC Home / Foyer de SLD :	WILLIAM A. "BILL" GEORGE EXTENDED CARE FACILITY 75 FIFTH AVENUE, SIOUX LOOKOUT, ON, P8T-1K9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Anderson

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To SIOUX LOOKOUT MENO-YA-WIN HEALTH CENTRE, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Linked to Existing Order / Lien vers ordre existant: 2014_211106_0010, CO #002;

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 ensure that each 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;

The licensee shall prepare, submit and implement a plan for achieving compliance with r. 15 (1) of the LTCHA. The plan is to include:
1) Steps to ensure that all bed systems are evaluated to minimize resident risk.
2) An auditing process to ensure that when mattresses are changed, the record is kept up to date and reflects the changes made.
3) Strategies to ensure that where bed rails are used, all residents receive an assessment.

The compliance plan is due to be submitted by August 31, 2015, to Debbie Warpula LTCH Nursing Inspector #577 via email. Implementation and full compliance with the plan is to be achieved by September 11, 2015.

Grounds / Motifs :

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

Non-compliance had previously been identified related to bed rails: During an inspection completed June 2014 under inspection #2014_211106_0010, one Compliance Order was issued pursuant to O.Reg 79/10, s. 15. (1) (a) the licensee failed to ensure that 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 risk to the resident.

Inspector #575 reviewed the health care records for resident #012, #014, and #015. The inspector noted that all three residents had a bed rail assessment completed using the home's form titled 'A Guide to Assist with the Decision Regarding the Use of Side Rails and Alternate Assistive Devices'.

The inspector interviewed the DOC regarding bed rails and bed system assessments. The DOC stated that residents are assessed for bed rails using the home's guide (as indicated above) and that the home had purchased the tools to assess the beds for entrapment and that all beds are purchased with mattresses to fit the bed. The DOC stated that the tools were recently bought and they are looking at training a staff member to assess the beds. To date, no beds have been assessed however they hope within the next 3 months that the beds will be assessed.

The inspector asked the DOC for a record of residents and their type of bed system. The DOC checked all of the beds and made corrections to the record. The record indicated that resident #012 and #015 had a specific type of bed and mattress, however, the inspector observed both bed systems and noted that both residents had a different type of mattress than indicated in the record, therefore the record was inaccurate. [s. 15. (1) (a)] (575)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 11, 2015

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

Linked to Existing Order / Lien vers ordre existant: 2014_211106_0010, CO #001;

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 the Continence Care and Bowel Management Program, has a written description of the program in place that includes its goals and objectives, relevant policies, procedures, and protocols, methods to reduce risk, outcomes monitoring, and protocols for referral of residents to specialized resources where required.

The licensee shall prepare, submit and implement a plan for achieving compliance with s. 30 (1) of the LTCHA. The plan is to include:
1) A process for developing and implementing a Continence Care and Bowel Management Program that meets the requirements of O. Reg 79/10, s. 30.

This compliance plan is due to be submitted by August 31, 2015, to Debbie Warpula LTCH Nursing Inspector #577 via email. Implementation and full compliance with the plan is to be achieved by September 11, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that there is a Continence Care and Bowel Management Program that has 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.

On April 7, 2015, Inspector #577 met with DOC regarding the Continence Care and Bowel Management Program. They reported that the program is in draft form and is not currently implemented in the home. It was further reported that staff use a Bladder and Bowel Continence Assessment on admission and complete a quarterly assessment.

A previous Compliance Order was issued August 20, 2014, log #S-000210-14, #2014_211106_0010 with a compliance date of September 30, 2014.

Compliance Order #001 that was issued on August 20, 2014, ordered the licensee to do the following:
"The licensee shall ensure that the organized program required under section 48 of the Regulation, specifically the Continence Care and Bowel Management Program, that there is a written description of the program that includes its goals and objectives, relevant policies, procedures, and protocols, methods to reduce risk, outcomes monitoring, and protocols for referral of residents to specialized resources where required". [s. 30. (1) 1.] (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 11, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 19th day of August, 2015

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Debbie Warpula

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