Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 25, 2017;	2017_689586_0003 (A3)	021617-17	Resident Quality Inspection

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Willowgrove Long Term Care Residence
1217 Old Mohawk Road ANCASTER ON L9K 1P6

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

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Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

JESSICA PALADINO (586) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

Date revision.

Issued on this 25 day of October 2017 (A3)

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

Original report signed by the inspector.

Ontario

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JESSICA PALADINO (586) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): September 12, 13, 14, 15, 18, 19, 20, 21, 22 and 25, 2017.

The following Critical Incident System (CIS) Inspections were conducted concurrently with the Resident Quality Inspection (RQI):

000904-16 - Falls Prevention & Management

020587-16 - Falls Prevention & Management

029330-16 - Falls Prevention & Management

032911-16 - Prevention of Abuse & Neglect

000190-17 - Medication Management

004256-17 - Prevention of Abuse & Neglect

006576-17 - Responsive Behaviours

007321-17 - Responsive Behaviours

008561-17 - Responsive Behaviours

008567-17 - Medication Management

008729-17 - Prevention of Abuse & Neglect

009273-17 - Prevention of Abuse & Neglect

020022-17 - Medication Management.

The following Complaint Intakes were completed concurrently with the RQI:

005376-17 - Medication Management; Prevention of Abuse & Neglect; Personal Support Services

005841-17 - Residents' Rights

007188-17 - Falls Prevention & Management; Medication Management; Personal Support Services; Infection Prevention & Control.

The following Follow Up Inspections were completed concurrently with the RQI:

004762-17 - Continence Care & Bowel Management

004764-17 - Skin & Wound Management.

The following Inquiries were completed concurrently with the RQI:

003403-16 - Falls Prevention & Management

014694-16 - Responsive Behaviours

032593-16 - Responsive Behaviours

034444-16 - Responsive Behaviours

004552-17 - Falls Prevention & Management

009803-17 - Responsive Behaviours

014190-17 - Responsive Behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, Directors of Care (DOC), Assistant Director of Care (ADOC), Social Worker, Program Support Services Manager, Resident Assessment Instrument (RAI) Co-ordinator, Environmental Services Manager (ESM), Registered Dietitians (RD), Assistant Food Services Manager (AFSM), Behavioural Support Ontario (BSO) Clinical Coach, Regional Consultant, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents, and families.

During the course of the inspection, the inspectors reviewed resident health records, medication incident investigation notes, audits, policies and procedures, and internal investigation records, interviewed staff and observed resident care.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

17 WN(s)
9 VPC(s)
4 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 50. (2)	CO #002	2016_215123_0014	506
LTCHA, 2007 s. 91. (4)	CO #001	2016_215123_0014	156

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that every resident was protected from abuse and neglect.

A. On an identified date in 2017, RPN #101 and PSW #011 witnessed PSW #009 raising their voice at resident #021 while providing care, and the resident became agitated in response.

Review of the home's internal investigation notes and interview with DOC #1 on September 14, 2017, confirmed the incident and that PSW #009 was disciplined as a result. They acknowledged that resident #021 was not protected from verbal abuse.

B. On an identified date in 2017, RPN #101 observed that the call bells were removed from residents #022 and #023's rooms. Two days later, PSW #100 reported that the call bell was missing from resident #023's room.

Interview with PSW #102 on September 14, 2017, and review of the home's internal investigation notes confirmed that they removed the call bell from resident #023's room more than once.

PSW #102 acknowledged the risk this posed to the resident and the Administrator confirmed that these actions constituted resident neglect. Resident #022 was not protected from neglect.

C. Resident #025's documented plan of care indicated that they displayed specific responsive behaviours.

On an identified date in 2017, staff found resident #026 injured as a result of an altercation between them and resident #025.

Review of the home's internal investigation notes and interview with the BSO Clinical Coach acknowledged that the incident occurred, and resident #026 was not protected from physical abuse by resident #025, resulting in injury.

D. Resident #027 was admitted to the secured home area of the home with a history of specific responsive behaviours.

On two separate identified dates in 2017, the resident was observed displaying these behaviours toward two co-residents.

In interviews with the BSO Clinical Coach and the ADOC on September 20, 2017, BSO indicated that the resident was aware of their actions. The ADOC acknowledged that these incidences constituted abuse as the co-residents were unable to consent to the acts. Residents #025 and #028 were not protected from abuse by co-resident #027. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, could be easily seen, accessed and used by residents, staff and visitors at all times.

The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times.

A) During Stage 1 of the RQI, the Long Term Care Home (LTCH) Inspector activated a resident room call bell and a bathroom call bell on an identified home area. After 15 minutes, no staff responded. The LTCH Inspector located two PSWs, PSWs # 001 and #002, who were in another resident room. PSW #008 was on break. Upon asking the staff whether they had been notified on their pagers of any call bells recently, they both stated they had not. PSW #001 did not have a pager as it was out for repair. PSW #002 had a pager but the pager was not reliable. The PSW informed the LTCH Inspector their pager did not always pick up the call bells. The PSW who was on break did not have a pager as it was out for repair. Staff was not aware that any call bells had been activated.

The resident call bell in an identified room was activated by the LTCH Inspector three times and the light did not turn on over the bedroom door. The LTCH Inspector had PSW #008 try the call bell twice with the same result. The call bell, once triggered, did not go to the one remaining pager.

Review of the home's policy, "Resident Safety – Door Alarms, Nurse Call System and Rounds" (policy number LTC-CA-WQ-200-07-10, revised May 2012), directed staff to carry a pager which accepted a signal when a resident triggers an alarm and staff was to respond to the call bell in a timely manner. The nurse call system had pull stations in all resident areas to support resident's ability to call for assistance when needed. On September 12, 2017, one identified home area had one pager available to staff. Another identified home area had two pagers.

Interview with RPN #003 regarding the PSW pagers; they told the LTCH Inspector they were not responsible for the PSW pagers and took no action regarding the missing two pagers. PSWs #008 and #002 had informed the LTCH Inspector they had notified RPN #003 the previous day that two pagers were missing. The RPN explained when a call bell was not answered in four minutes, the call bell was forwarded to the nurse's Ascom phone. Currently this phone is not available to staff as it is in non-working order.

During an interview with the Administrator, they told the LTCH Inspector they were not aware of the missing pagers. It was an expectation of the home that when a pager was missing, the PSW was to notify the unit nurse who would notify either the DOC or the ESM who would take action. The home would usually have six back up pagers, however, there were only two available in the home. The Administrator confirmed the home does not have a policy regarding the use of the pagers, call bell system and required actions. (640).

B) On an identified date in 2017, RPN #101 observed that the call bells were removed from residents #022 and #023's rooms. Two days later, PSW #100 reported that the call bell was missing from resident #023's room. Review of the home's internal investigation notes and interview with DOC #1 and the Administrator on September 14, 2017, confirmed that the call bells were removed from the residents' rooms. The home did not ensure that the resident-staff communication response system was easily accessible and able to be used by residents #022 and #023. [s. 17. (1) (a)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the registered dietitian who was a member of the staff of the home (a) completed a nutritional assessment for the resident whenever there was a significant change in the resident's health condition; and (b) assessed the resident's hydration status, and any risks related to hydration.

A) Resident #008 was experiencing dehydration for a period of time in 2017. A referral was made by the FSM to the RD regarding another issue the resident was experiencing, but did not include any mention of the dehydration. The RD assessed the resident five days later; however, this significant change in the resident's health condition or the resident's hydration status were not assessed. This was confirmed with the RD on September 18, 2017.

B) On an identified date in 2017, resident #007 was noted to have a change in their condition and staff were to monitor and push fluids by the physician. A review of the fluid intake sheets for a three-day period indicated that the resident was significantly below their fluid target intake; however, a referral to the RD was not completed as per the home policy.

Referrals were made to the RD regarding other issues the resident was experiencing; however, when the RD responded to the referrals, there was no assessment of hydration status or any risks related to hydration even though the resident was experiencing a change in condition and staff were pushing fluids during this time. This was confirmed with the RD on September 20, 2017. [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident. As a result of a critical incident inspection, CIS log #020022-17, the LTCH Inspector reviewed medication incidents over a three month period in 2017, and one specific medication incident that occurred on an identified date in 2017. In total, 14 incident reports were reviewed.

Of the 14 reviewed, six medication incidents involved residents being administered another resident's medications and two were medications administered but not prescribed.

During an interview with DOC, they confirmed the identified residents were administered medication(s) that had not been prescribed to the resident. [s. 131. (1)]

2. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

On an identified date in 2017, resident #201 returned from the hospital with a change in one of their medications. RN #018 transcribed the orders to the electronic Medication Administration Record (eMAR) incorrectly, and the resident received the first dose from RPN #030 and the second dose from RPN #031. The resident experienced a negative outcome to their health as a result.

According to the home's investigative records and the Administrator of the home, there was confirmation that RN #018 incorrectly transcribed the medication orders upon resident #201's return from the hospital which caused RPN #031 to administer a second dose to the resident, which was not in accordance with the directions as specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

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

Findings/Faits saillants :

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

Resident #103 had a list of specific interventions located in the front of their chart, at the request of the SDM. The list had been subject to many changes and items had been removed and added several times. Interview with nursing staff #004, #036 and #037 confirmed they were not aware of any specific instructions or interventions regarding this resident. In an interview with the Administrator, who looked at the list of interventions with the LTC Inspector, they also confirmed the interventions were not clear and revised the list on the same day so the interventions were clear for all staff to follow. [s. 6. (1) (c)]

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

The plan of care for resident #008 indicated that the resident was at risk for dehydration. Progress notes from an identified period of time in 2017, indicated that the resident was experiencing associated symptoms. It was noted that the physician thought the resident was dehydrated.

i. The Minimum Data Set (MDS) Section J Health Conditions 1. Problem Conditions indicated that the resident was dehydrated.

ii. The nutrition/hydration risk assessment tool did not indicate that the resident was experiencing signs and symptoms of dehydration.

iii. The RD assessed the resident later the same month; however, hydration status was not assessed.

The staff and others involved in the different aspects of care failed to collaborate with each other in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with and complement each other with regards to the resident's hydration status as confirmed with the RD on September 18, 2017. [s. 6. (4) (b)]

3. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given the opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #103 was able to make decisions regarding certain aspects of their care and was able to answer simple questions requiring yes or no answers. A review of the resident's clinical record confirmed on four occasions that the resident was not given the opportunity to participate fully in the development of their plan of care.

The Administrator confirmed that the resident was able to make these decisions regarding their care and that staff were to assess the resident in each situation. [s. 6. (5)]

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

During the observation of the medication administration pass on a specific home area, the LTC Inspector observed RPN #003 administer resident #205's prescribed fluid with the medication pass. The LTCH Inspector reviewed the plan of care, specifically the electronic eMAR, which directed staff to offer an identified amount of a specific fluid with each medication administration.

During the clinical record review by the LTCH Inspector, the RD had identified resident #205 at nutritional risk and risk of dehydration. They had ordered an identified amount of a specific fluid be administered with each medication pass as an intervention.

During an interview with RPN #003, the nurse administering medications, they confirmed they had not offered the prescribed amount of fluid and had documented (signed) as having offered the fluid to resident #205 during the medication pass.

During an interview with DOC #2, they told the LTCH Inspector it was an expectation of the home that staff provide the care as set out in the plan of care. The DOC confirmed this had not been done with the administration of the incorrect amount of fluid. [s. 6. (7)]

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

During the observation of the medication administration pass on an identified home

area, the LTCH Inspector observed RPN #003 administer resident #205's medication crushed in applesauce. The LTCH Inspector reviewed the plan of care which directed staff to administer medications whole. RPN #003 confirmed the plan of care which directed staff to administer medications whole.

Interview with RPN #003, the nurse administering the medication, revealed that the resident began having swallowing difficulty. The RD assessed the resident and changed the diet texture to assist with the resident's swallowing.

The RPN told the LTCH Inspector they had spoken with the resident's Power of Attorney for Care (POAPC), who gave consent to crush the medication sometime. After review of the clinical record by the LTCH Inspector and RPN #003, it was confirmed there was no documentation regarding this discussion. RPN #003 informed the LTCH Inspector they were not aware of how to make changes to the plan of care so therefore when the resident's condition changed to need crushed medications, the RPN did not update the plan of care to reflect the changes.

Interview with DOC #2 confirmed the home expected the RPN to change the plan of care when the resident's care needs changed. The resident's care needs changed and the licensee failed to ensure the plan of care was reviewed and revised. [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 staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated, consistent with and complemented each other, and to ensure that every resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with related to s. 20 (2) (d), the duty under section 24 to make mandatory reports.

A. The home's policy, "Abuse Allegations and Follow-Up" (policy number LTC-CA-WQ-100-05-02, last revised July 2016) directed staff to mandatorily report abuse immediately, and that if there was any doubt or question as to where or not the incident was to be reported to regulatory bodies, to always make the report. The policy also indicated that staff who witnessed or were knowledgeable about abuse or alleged abuse must understand that they were obligated by legislation to report the incident to a Regulatory or Licensing Authority such as Ministry of Health and Long-Term Care or a regional health authority.

On an identified date in 2016, alleged verbal abuse toward resident #020 was witnessed and reported to the home. The Director was not notified of the incident until two days later. The Administrator confirmed this, and acknowledged that the incident should have been immediately reported.

B. The home's policy, "Abuse Allegations and Follow-Up" (policy number LTC-CA-WQ-100-05-02, last revised July 2016) indicated that abuse reporting was immediate and mandatory and that all employees were required to report immediately to their respective supervisor/person in charge of the building when an abuse was witnessed or suspected.

On an identified date in 2017, RPN #010 witnessed PSW #009 verbally abusing resident #021. They wrote a progress note in Point Click Care (PCC) about the incident, but did not report it to their supervisor. DOC #1 returned to work two days later, and reviewed the progress note, then notified the Director.

Interview with the DOC #1 on September 14, 2017, confirmed that RPN #010 should have immediately reported the incident to the RN in charge who would then notify the on-call manager to report the incident to the Director. The DOC confirmed that the Director was not notified immediately of the incident of verbal abuse toward resident #021.

C. On an identified date in 2017, RPN #101 observed that the call bells were removed from residents #022 and #023's rooms. Two days later, PSW #100 reported that the call bell was missing from resident #023's room. Interview with DOC #1 on September 14, 2017, confirmed that the Administration was not notified

of the concern two days after that, when the RPN returned to work for their next shift. The DOC then notified the Director. They indicated that the RPN should have notified their supervisor or manager when PSW #100 reported this to them, and that the Director was not immediately notified.

D. On an identified date in 2017, PSW #046 witnessed an incident of inappropriate sexual behaviour between two residents. The PSW immediately reported this to RPN #041 who reported it to RN #052. Interview with the Administrator confirmed that RN #052 did not report the incident to their supervisor until the following day, when the home then notified the Director. They confirmed that the Director was not notified immediately of the incident of sexual abuse toward resident #028. [s. 20. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents is complied with related to s. 20 (2) (d), the duty under section 24 to make mandatory reports, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

A. On an identified date in 2016, resident #320 experienced an unwitnessed fall resulting in significant injury. While awaiting a diagnosis, staff were transferring the resident in and out of bed in a way that was not indicated in their plan of care.

DOC #2 confirmed on September 27, 2017, that staff failed to use safe transferring and positioning devices or techniques as per the plan of care to assist this resident after they experienced a fall with injury. (156).

B. The home's policy, "Safe Transfer Program" (policy number LCT-CA-WQ_200-07-15, last revised February 2016) directed staff to assess the resident prior to any transfer and use the information identified on their care plan.

Review of resident #024's documented plan of care indicated that the resident required a specific type of assistance to and from bed, though an alternate transfer type was required when they were weak or tired.

On an identified date in 2017, PSW #035 transferred the resident from their wheelchair into bed alone. The resident confirmed that the PSW did not use the assistance of another person nor did they use a designated device. Review of the home's internal investigation notes and interview with the Administrator on September 19, 2017, confirmed this. The PSW acknowledged that they transferred the resident independently. PSW #035 did not transfer resident #024 using safe transferring techniques. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #8: 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 failed to ensure that the home's nutrition care and dietary services programs included, (a) the development and implementation, in consultation with a registered dietitian who was a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration.

On September 20, 2017, RD #1 confirmed that they were not consulted in the development and implementation of policies and procedures relating to nutrition

care and dietary services and hydration in the home.

2. The licensee failed to ensure that the nutrition care and dietary services program, b) included the identification of any risks related to nutrition care, dietary services, and hydration with c) the implementation of interventions to mitigate and manage those risks.

The home's policy, "Food and Nutrition Services Hydration Program" (effective July 2010, last revised January 2015) was not clear on when to initiate strategies to correct poor hydration. The policy, as it was being applied by staff did not ensure that risks related to hydration were identified and interventions to mitigate and manage those risks were implemented in a timely manner.

The policy stated that if a resident's intake was 1000 ml fluid or less for three consecutive days resident #007 would be referred to the RD. This policy was not always followed.

The individual fluid intake sheets for six months in 2017 for resident #007 indicated that there were several occasions where the resident's intake was less than 1000 ml/day for three consecutive days or more and was not referred to the RD. This was confirmed with the RD on September 18, 2017.

The policy indicated that the RD or designate was responsible to follow up with any resident who had been identified at risk as outlined below:

Monthly for residents at high risk for dehydration: resident's response to interventions, revisions to interventions and resolution of risk, revision of weight and BMI, evaluate improvement or deterioration in resident' condition, recommendations for further investigations and laboratory work.

Quarterly for residents at low risk of dehydration: changes in vital signs, weight, laboratory values and medications, summary of interventions and resident's response, evaluate improvement or deterioration in resident's condition, any further testing/assessment being considered, review and update care plan on an on-going basis.

i. Resident #007 was deemed to be at identified nutritional risk and therefore, followed by the RD (as reported by the RD and FSM). The RD or designate did not follow up with the resident with regards to hydration on a monthly basis as

confirmed with the RD on September 20, 2017.

ii. Resident #008 was deemed to be at an identified nutritional risk and therefore, followed by the FSM (as reported by the RD and FSM). The care plan for this resident indicated under the focus of 'dehydration/fluid maintenance' that the resident would maintain adequate fluid hydration by meeting sufficient fluid intake volumes and to monitor for signs of dehydration initiated by registered staff on October 23, 2014.

The FSM reported on September 13, 2017, that hydration was not assessed for residents deemed to be at moderate nutritional risk on a regular basis and that they did not routinely assess for hydration risk level for this resident or any residents that she followed.

Although residents were assessed on admission for individual fluid requirements, there were no measures in place to assess these requirements when all residents were only referred if less than 1000 ml/day x 3 days as per the policy.

i. The care plan for resident #007 indicated that the resident would maintain nutrition and hydration according to the individual assessed needs; however, a review of the fluid intake sheets for the last six months indicated that the resident only met this goal on nine days during this time period. No dietary referrals were sent to assess hydration status during this time.

ii. The care plan for resident #008 indicated the resident would have sufficient fluid intake volumes and to monitor for signs of dehydration initiated by registered staff. The individual assessed needs were calculated on admission and the last calculated hydration requirements were found to be 1500 ml/day calculated on an identified date in 2015. A review of the clinical record did not indicate that there had been any assessment of fluid requirements since that time as confirmed with the FSM on September 13, 2017. A review of the fluid intake sheets for the last six months indicated that the resident met the goal 48/176 or approximately 28% of the time.

The RD confirmed that dietary referrals were not always sent and therefore, not all residents at risk for poor hydration would be identified with action taken to address the poor hydration in a timely manner.

The RD from the home as well as RD #2 (interviewed on September 20, 2017) and

RD #3 (interviewed on September 21, 2017) who spoke to the inspector with regards to the policy, were unable to provide best practice documentation to support using 1000 ml/day of hydration target as the threshold for assessment and implementation of interventions to correct the poor hydration. The home's policy did not address changes in hydration/fluid consumption until residents reached the high nutrition and hydration risk category and were referred to the RD and was not preventative with strategies being initiated early to prevent the high risk concerns.

The "Best Practices for Nutrition, Food Service and Dining in Long Term Care Homes" document, written by the Ontario Long Term Care Action Group Dietitians of Canada, June 2007 revised April 2013, identified that homes should establish procedures for corrective actions, and documentation of same, when fluid intake did not meet residents requirements or when there was a change in the residents hydration status.

The presentation at the Dietitians of Canada conference, June 11, 2016 "Proactive Management of Dehydration in LTC" presented by Twinkle Patel RD, Seasons Care Inc. and Stacey Scaman RD, Seasons Care Inc. identified the need for a proactive versus a reactive approach to hydration in Long Term Care Homes.

The home's current hydration policy was not clear in relation to when staff were to intervene (three consecutive days of poor hydration below the resident's assessed hydration target or three consecutive days of 1000 ml or less). The home's implementation of the program using 1000 ml/day or less over a three day period was not based on evidence based practices and did not ensure that action was taken in a timely manner when risks related to hydration were identified. [s. 68. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the nutrition care and dietary services program includes the identification of any risks related to nutrition care, dietary services, and hydration with the implementation of interventions to mitigate and manage those risks, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service; O. Reg. 79/10, s. 90 (2).
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and O. Reg. 79/10, s. 90 (2).
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that, (a) electrical and non-electrical equipment, including mechanical lifts, were kept in good repair, and maintained and cleaned at a level that met manufacturers specifications, at a minimum; and (b) all equipment, devices, assistive aids and positioning aids in the home were kept in food repair, excluding the residents' personal aids and equipment.

During Stage 1 of the Resident Quality Inspection (RQI), the Long Term Care Home (LTCH) Inspector activated a resident room call bell and a bathroom call bell on an identified home area which housed 27 residents. After 15 minutes, no staff responded. Upon asking staff whether they had been notified on their pagers of any call bells recently, they both stated no. PSW #001 did not have a pager as it was out for repair. PSW #002 had a pager but the pager was not reliable. The PSW informed the LTCH Inspector their pager did not always pick up the call bells. The PSW who was on break did not have a pager as it was out for repair. Staff was not aware that any call bells had been activated. On September 12, 2017, an identified home area had one pager available to staff. Another identified home area had two pagers.

The resident call bell in an identified area was activated by the LTCH Inspector three times and the light did not turn on over the bedroom door. The LTCH Inspector had PSW #008 try the call bell twice with the same result. The call bell, once triggered, did not go to the one remaining pager.

Interview with RPN #003 regarding the PSW pagers; they told the LTCH Inspector they were not responsible for the PSW pagers and took no action regarding the missing two pagers. PSWs #008 and #002 had informed the LTCH Inspector they had notified RPN #003 the previous day that two pagers were missing.

The LTCH Inspector interview RN #005 who stated when they require maintenance for pagers, they tell the ESM when they see them in the hallway. The RN confirmed they do not enter the information in the Maintenance Log book.

The home’s policy, Maintenance Work Order and Log Book, policy number ALL-CA-ALL-505-02-05 and revised January 2015 directed staff to document in the maintenance log book when equipment required service. The policy further directed the maintenance staff to monitor the log books daily, complete repairs and sign off.

During an interview with the Administrator, they told the LTCH Inspector they were not aware of the missing pagers. It was an expectation of the home that when a pager was missing, the PSW was to notify the unit nurse who would notify either the DOC or the ESM who would take action.

The Administrator stated it was an expectation of the home that when a pager was missing or broken that staff document on the Maintenance Log book on the home area, maintenance would review the log daily and complete the document as per the home's policy and expectation.

Review of the log book on an identified home area revealed one notation in 2017 that three pagers were not working. There were no remarks, date of completion or signature of the maintenance department. Review of the Maintenance Log book on another identified home area did not reveal any documentation regarding the PSW pagers.

The pagers were identified to be in need of repair according to the system for communication with maintenance in the home and they were not repaired. [s. 90. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented to ensure that, (a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturers specifications, at a minimum; and (b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids and equipment, to be implemented voluntarily.

WN #10: 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. Every licensee of a long-term care home shall ensure that, (a) drugs were stored in an area or a medication cart, (ii) that was secured and locked.

On September 12, 2017, at approximately 1100 hours, the LTC Inspector observed an unlocked treatment cart in a resident's room. The resident in the room was seated beside the unlocked treatment cart. The unlocked treatment cart was left unattended for greater than 15 minutes and the LTC Inspector had access to prescribed treatment creams. Interview with the RPN #006 confirmed they had left the treatment cart unlocked, unattended and out of their site while they had been looking for treatment supplies. [s. 129. (1) (a) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart that is secured and locked, to be implemented voluntarily.

WN #11: 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 failed to ensure a monthly audit was undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies and that immediate action was taken if any discrepancies were discovered.

Monthly narcotic count audits reviewed by the LTC Inspector revealed monthly audits of the daily count sheets of controlled substances to be incomplete as follows;
i. There were no audits completed in January 2017 for all home areas;
ii. February 2017 audits were completed for all home areas;
iii. March 2017, one identified home area's narcotic count audit was not completed;
iv. April 2017 audits were not completed for all home areas; and,
v. May 2017, two identified home areas were not completed.

Policy review of "Monthly Narcotic Audit" (policy #LTC-CA-WQ-200-06-13 revised November 2011) directed staff to audit the narcotic count sheet for each home area on a monthly basis. An RN as designated by the DOC and the RPN on the home area, are to complete the audit together. Any discrepancies were to be reported to the DOC and the Administrator immediately.

During an interview with the DOC #2, they told the LTCH Inspector they were usually the RN participating in the audit on each home area. There were no notes made as to the action taken with any of the discrepancies. The DOC knew who did not sign for a narcotic and spoke with them individually. The DOC confirmed there was no documentation of immediate action taken as a result of the audit of the daily count sheets of controlled substances and that not all required audits had been completed. [s. 130. 3.]

Additional Required Actions:

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

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was, (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The LTCH Inspector reviewed three months of medication incidents as part of an inspection.

Review of random sample of medication incident reports identified that not all parties were notified of medication incidents as per requirement, including the Medical Director, attending Physician, DOC, prescriber, and resident/SDM.

Of the 14 medication incidents reviewed by the LTCH Inspector, six involved residents receiving other resident's medications.

DOC #2 was interviewed regarding the medication incidents and they told the LTCH Inspector there was no documentation that the incidents listed were reported to all persons required. [s. 135. (1)]

Additional Required Actions:

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

WN #13: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the home's infection prevention and control program related to labelling of personal care items.

The following were observed:

i. On September 12, 2017, two unlabelled and used roll-on deoderants, two used and unlabelled hair brushes with hair in them and two used hair combs were found in the spa room on an identified home area.
ii. On September 12, 2017, a used and unlabelled hair comb was found in the spa room on an identified home area.
iii. On September 12, 2017, a used and unlabelled hair comb was found in the spa room on an identified home area.
iv. On September 12, 2017, a used and unlabelled hair brush was found in the spa room on an identified home area.

The ADOC confirmed that all personal items were to be labelled. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the home's infection prevention and control program related to labelling of personal care items, to be implemented voluntarily.

WN #14: 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. Where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.

A. In accordance with Ontario Regulation (O. Reg) 79/10, r. 48. (1) required every licensee of a long term care home to ensure that the following interdisciplinary programs were developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The home's program, "Resident Safety and Risk Management Head Injury Routine" (last revised November 2014) stated that any resident who may have sustained an injury to their head as a result of a fall or other such incident where the resident's head may come in contact with a hard surface would have a head injury routine initiated. Once initiated, the head injury routine would continue for 72 hours unless it is ordered discontinued by the physician/nurse practitioner. Registered staff would transfer a resident to hospital if they at any point in time have concerns about the neurologic status of a resident who has sustained or has a suspected head injury.

Interview with the RAI coordinator and the ADOC confirmed that all unwitnessed falls would result in the initiation of the Head Injury Routine.

On an identified date in 2016, resident #320 experienced an unwitnessed fall resulting in a significant injury. Review of the clinical record revealed no Head Injury Routine was completed.

Interview with the RAI Coordinator, ADOC and DOC #1 confirmed that the Head Injury Routine was to be completed for all unwitnessed falls and that registered staff did not initiate the Head Injury Routine prior to transfer to hospital the following day. (156).

B. During the initial tour of the home on September 12, 2017, it was noted that the tub on an identified home area was very soiled in an interview with PSW #033 reported to me the tub was not in working condition because it leaks and has been broken for a while. In an interview with the ESM on September 15, 2017, they confirmed they were unaware that the tub was broken and it leaked. A review of the log book on the home area revealed that there were no entries regarding the tub and the ESM confirmed that they went back all the way back to December 2016 and there were no entries entered in the Maintenance Work Order and Log book.

The home failed to ensure the Maintenance Work Order and Log Book policy was complied with. [s. 8. (1) (b)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence.

Resident #027 was admitted to the secured home area of the home with a history of identified responsive behaviours. In interviews with the BSO Clinical Coach and the ADOC on September 20, 2017, BSO indicated that the resident was aware of what they were doing.

On an identified date in 2017, the resident displayed the identified responsive behaviour toward a co-resident.

The home's policy, "Abuse Allegations and Follow-Up" (policy number LTC-CA-WQ-100-05-02, last revised July 2016) directed staff to report to the police if there was any perception that a criminal offence may have happened. The Administrator indicated that the home followed a document provided by the Hamilton Police Service to the home, providing specific direction on reporting requirements, which included that incidences of sexual abuse should be reported to them through their intake referral form.

Interview with DOC #2 and the Administrator on September 22, 2017, confirmed that the police were not notified of the incident of sexual abuse, and DOC #2 acknowledged that this should have been done. [s. 98.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,

i. a breakdown or failure of the security system,

ii. a breakdown of major equipment or a system in the home,

iii. a loss of essential services, or

iv. flooding.

O. Reg. 79/10, s. 107 (3).

3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of the following incidents in the home no later than on business day after the occurrence of the incident, followed by the report required under subsection (4); 3. A missing or unaccounted for controlled substance; and, 5. A medication incident or adverse drug reaction in respect of which a resident was taken to the hospital.

i) An identified medication was unaccounted for after application on resident #200. The home was aware of the missing medication and did not report it until five days later.

ii) Resident #201 was administered medications prescribed to another resident which resulted in transfer to hospital. The incident was reported 12 days later.

DOC #2 confirmed to the LTC Inspector that the Director was not informed of the incidents within one business day as was required. [s. 107. (3)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (3) The annual evaluation of the medication management system must,
(a) include a review of the quarterly evaluations in the previous year as referred to in section 115; O. Reg. 79/10, s. 116 (3).
(b) be undertaken using an assessment instrument designed specifically for this purpose; and O. Reg. 79/10, s. 116 (3).
(c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 116 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the annual evaluation of the medication management system included, (a) a review of the quarterly evaluations in the previous year as referred to in section 115; and, (c) identified changes to improve the system in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

During the RQI, the LTC Inspector reviewed the annual evaluation of the medication management system which was held May 25, 2017. The documentation did not address the outcomes of the quarterly medication management system evaluation which included medication incidents, nor were there any identified changes to improve the system in accordance with evidence-based practices and, where there were none, in accordance with prevailing practices.

DOC #2 confirmed, during an interview with the LTCH Inspector, the annual evaluation of the medication management system did not review the medication incidents from the quarterly evaluations and did not identify changes to improve the system. [s. 116. (3)]

Issued on this 25 day of October 2017 (A3)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JESSICA PALADINO (586) - (A3)

Inspection No. / No de l'inspection : 2017_689586_0003 (A3)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 021617-17 (A3)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Oct 25, 2017;(A3)

Licensee / Titulaire de permis :
Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

LTC Home / Foyer de SLD :
Chartwell Willowgrove Long Term Care Residence
1217 Old Mohawk Road, ANCASTER, ON, L9K-1P6

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Natasha Murray

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To Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner, 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)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that every resident, including residents #021, #022, #025 and #028, is protected from verbal and physical abuse by anyone, including staff, and to ensure that residents are not neglected by the licensee or staff.

The plan should be submitted via email by November 23, 2017, to Jessica Paladino via e-mail at HamiltonSAO.MOH@ontario.ca.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (2) and compliance history (4), in keeping with s.299 (1) of the Regulation, in respect of the actual harm that resident's #021, #022, #025 and #028 experienced, the scope of a widespread issue, and the Licensee's history of non-compliance (VPC) on the February 22, 2017, Resident Quality Inspection with the s.19 related to resident abuse and neglect.

The licensee failed to ensure that every resident was protected from abuse and

neglect.

A. On an identified date in 2017, RPN #101 and PSW #011 witnessed PSW #009 raising their voice at resident #021 while providing care, and the resident became agitated in response.

Review of the home's internal investigation notes and interview with DOC #1 on September 14, 2017, confirmed the incident and that PSW #009 was disciplined as a result. They acknowledged that resident #021 was not protected from verbal abuse.

B. On an identified date in 2017, RPN #101 observed that the call bells were removed from residents #022 and #023's rooms. Two days later, PSW #100 reported that the call bell was missing from resident #023's room.

Interview with PSW #102 on September 14, 2017, and review of the home's internal investigation notes confirmed that they removed the call bell from resident #023's room more than once.

PSW #102 acknowledged the risk this posed to the resident and the Administrator confirmed that these actions constituted resident neglect. Resident #022 was not protected from neglect.

C. Resident #025's documented plan of care indicated that they displayed specific responsive behaviours.

On an identified date in 2017, staff found resident #026 injured as a result of an altercation between them and resident #025.

Review of the home's internal investigation notes and interview with the BSO Clinical Coach acknowledged that the incident occurred, and resident #026 was not protected from physical abuse by resident #025, resulting in injury.

D. Resident #027 was admitted to the secured home area of the home with a history of specific responsive behaviours.

On two separate identified dates in 2017, the resident was observed displaying these behaviours toward two co-residents.

In interviews with the BSO Clinical Coach and the ADOC on September 20, 2017, BSO indicated that the resident was aware of their actions. The ADOC acknowledged that these incidences constituted abuse as the co-residents were unable to consent to the acts. Residents #025 and #028 were not protected from abuse by co-resident #027. (586)

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

Dec 20, 2017

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

The licensee shall ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

1) The licensee is to develop and conduct an audit of the home's resident-staff communication and response system. The audit will be documented and accessible to inspectors during the follow up inspection.

2) The licensee is to provide training to all direct care staff regarding their responsibilities related to the resident-staff communication system and the home's policy and procedure for the communication system.

3) The licensee is to develop and implement an audit tool to determine staff compliance with the expectations related to the resident-staff communication system.

4) The licensee is to ensure an adequate supply of back up equipment (pagers and Ascom phones) that is working and available in the home at all times.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (2) and compliance history (4), in keeping with s.299 (1) of the Regulation, in respect of the potential for actual harm toward residents in the affected home areas, the scope of a pattern, and the Licensee's history of non-compliance in unrelated areas.

The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times.

A) During Stage 1 of the RQI, the Long Term Care Home (LTCH) Inspector activated a resident room call bell and a bathroom call bell on an identified home area. After 15 minutes, no staff responded. The LTCH Inspector located two PSWs, PSWs # 001 and #002, who were in another resident room. PSW #008 was on break. Upon asking the staff whether they had been notified on their pagers of any call bells recently, they both stated they had not. PSW #001 did not have a pager as it was

out for repair. PSW #002 had a pager but the pager was not reliable. The PSW informed the LTCH Inspector their pager did not always pick up the call bells. The PSW who was on break did not have a pager as it was out for repair. Staff was not aware that any call bells had been activated.

The resident call bell in an identified room was activated by the LTCH Inspector three times and the light did not turn on over the bedroom door. The LTCH Inspector had PSW #008 try the call bell twice with the same result. The call bell, once triggered, did not go to the one remaining pager.

Review of the home's policy, "Resident Safety – Door Alarms, Nurse Call System and Rounds" (policy number LTC-CA-WQ-200-07-10, revised May 2012), directed staff to carry a pager which accepted a signal when a resident triggers an alarm and staff was to respond to the call bell in a timely manner. The nurse call system had pull stations in all resident areas to support resident's ability to call for assistance when needed. On September 12, 2017, one identified home area had one pager available to staff. Another identified home area had two pagers.

Interview with RPN #003 regarding the PSW pagers; they told the LTCH Inspector they were not responsible for the PSW pagers and took no action regarding the missing two pagers. PSWs #008 and #002 had informed the LTCH Inspector they had notified RPN #003 the previous day that two pagers were missing. The RPN explained when a call bell was not answered in four minutes, the call bell was forwarded to the nurse's Ascom phone. Currently this phone is not available to staff as it is in non-working order.

During an interview with the Administrator, they told the LTCH Inspector they were not aware of the missing pagers. It was an expectation of the home that when a pager was missing, the PSW was to notify the unit nurse who would notify either the DOC or the ESM who would take action. The home would usually have six back up pagers, however, there were only two available in the home. The Administrator confirmed the home does not have a policy regarding the use of the pagers, call bell system and required actions.

The two back up pagers were distributed, one to each of these home areas leaving Old Mill with one pager missing and one pager unreliable. The Administrator informed the LTCH Inspector the Ascom phones frequently are out for repair. Currently there are two in the home of a possible six. The two Ascom phones were

assigned to the Registered Nurse on each of the two floors.
(640)

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

Nov 30, 2017

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Order / Ordre :

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

The licensee shall prepare, submit and implement a plan to ensure that the registered dietitian, who is a member of the staff of the home, (a) completes a nutritional assessment for all residents, including residents #007 and #008, whenever there is a significant change in the resident's health condition; and (b) assesses the resident's hydration status, and any risks related to hydration.

The plan shall include:

A. An assessment of the current method of communication between nursing and dietary staff in regards to resident’s change in condition;

B. A review of the process for assessing resident change in condition, hydration status and risk levels for residents, and changes to be made;

C. Staff education that is to be completed and a record maintained of participants and dates of the education; and,

D. Quality management activities (including the type of activities and frequency) that will be implemented to target the specific area of non-compliance.

The plan should be submitted via email by November 23, 2017, to Carol Polcz via e-mail at HamiltonSAO.MOH@ontario.ca.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (2) and compliance history (4), in keeping with s.299 (1) of the Regulation, in respect of the potential for actual harm toward residents #007 and #008, the scope of a pattern, and the Licensee's history of non-compliance (VPC) on the February 22, 2017, Resident Quality Inspection with the r. 26 related to RD assessments.

The licensee failed to ensure that the registered dietitian who is a member of the staff of the home
(a) completed a nutritional assessment for the resident whenever there was a significant change in the resident's health condition; and
(b) assesses the resident's hydration status, and any risks related to hydration

A) Resident #008 was experiencing dehydration for a period of time in 2017. A referral was made by the FSM to the RD regarding another issue the resident was experiencing, but did not include any mention of the dehydration. The RD assessed the resident five days later; however, this significant change in the resident's health condition or the resident's hydration status were not assessed. This was confirmed with the RD on September 18, 2017.

B) On an identified date in 2017, resident #007 was noted to have a change in their condition and staff were to monitor and push fluids by the physician. A review of the fluid intake sheets for a three-day period indicated that the resident was significantly below their fluid target intake; however, a referral to the RD was not completed as per the home policy.

Referrals were made to the RD regarding other issues the resident was experiencing; however, when the RD responded to the referrals, there was no assessment of hydration status or any risks related to hydration even though the resident was experiencing a change in condition and staff were pushing fluids during this time. This was confirmed with the RD on September 20, 2017.
(156)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Dec 20, 2017

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Order / Ordre :

The licensee shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

1. All registered staff are to have face to face training on the home's policy and procedure regarding the safe administration of medications.

2. All registered staff are to review and sign off on that review, of the College of Nurse's Medication Standard.

3.The licensee is to develop and implement an audit to determine the root causes of medication errors that result from medication being administered to the wrong resident.

4. The licensee is to implement the changes to the Medication Management Program, based on the audit results, to decrease the number of incidents of this nature.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (2) and compliance history (3), in keeping with s.299 (1) of the Regulation, in respect of the actual harm the residents experienced, the scope of a pattern, and the Licensee's history of non-compliance in unrelated areas.

The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident. As a result of a critical incident inspection, CIS log #020022-17, the LTCH Inspector reviewed medication incidents over a three month periodin 2017, and one specific medication incident that occurred on an identified date in 2017. In total, 14 incident reports were reviewed.

Of the 14 reviewed, six medication incidents involved residents being administered another resident's medications and two were medications administered but not prescribed.

During an interview with DOC, they confirmed the above residents were administered medication(s) that had not been prescribed to the resident. (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Dec 20, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 25 day of October 2017 (A3)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JESSICA PALADINO - (A3)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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Service Area Office / Bureau régional de services : Hamilton