Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Feb 25, 2015	2014_205129_0017	H-000954-14	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE HALTON HILLS
9 Lindsay Court Georgetown ON L7G 6G9

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

PHYLLIS HILTZ-BONTJE (129), KATHLEEN MILLAR (527), VIKTORIA SHIHAB (584)

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): July 24, 25, 28, 29, 30, 31, August 1, 5, 7, 8, 11 and 12, 2014

During the course of the inspection, the inspector(s) spoke with residents, family members, registered and unregulated staff, the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Program Manager, the Minimum Data Set/Point Click Care Coordinator, the Food Services Manager, the Environmental Services Supervisor and Maintenance staff in relation to Log #H-000954-14.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
18 WN(s)
10 VPC(s)
5 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. 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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee did not ensure that all staff participated in the implementation of the infection prevention and control program, in relation to the following: [229(4)]
a) Staff did not participate in the implementation of the infection control program when they did not ensure that items used for the personal care of residents were labelled to prevent personal care items being used by multiple residents. On July 28, 2014 it was noted that two unlabelled hair brushes, unlabelled nail clippers and unlabelled deodorant were noted to be in a common use tub/shower room on the Wildwood home area.
b) Staff did not participate in the implementation of the infection control program when they did not ensure that soiled body fluid collection equipment was properly stored. On July 28, 2014 it was noted that urine collection containers were stored on the backs of toilets in shared resident washrooms in two identified resident rooms. [s. 229. (4)]

2. The licensee did not ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee, in relation to the following: [229(10)1]
The staff member who co-ordinates the infection prevention and control program in the home confirmed that the home is following the "Tuberculosis Screening Recommendations for Long –Term Care Homes" provided to them from the Halton Region Health Department. Included in the recommendations are directions that a person with unknown tuberculin skin test (TST) must have a two-step TST. The Halton

Region Health Department recommendations are included in the home's infection control manual.
a) Resident #025 did not receive complete screening for tuberculosis. The resident was admitted to the home on an identified date in 2014, staff interviewed and clinical documentation confirmed that step one TST was administered two days following admission; however, there was no indication in the clinical record that the results of this test were read by staff. Staff interviewed and the Medication Administration Record (MAR) confirmed that step two TST was administered 17 days following the step one TST; however, there was no indication in the clinical record that the results of this test were read by staff. Although the serum was administered to resident #025 there was no indication of the outcome of this screening for tuberculosis.
b)Resident #026 did not receive complete screening for tuberculosis. The resident was admitted to the home on an identified date in 2014. Information provided on admission to the home indicated that the resident received step one TST prior to admission and the results of this step of the screening was negative. Staff interviewed and clinical documentation confirmed that step two TST was not administered to the resident.
c) Resident #027 did not receive complete screening for tuberculosis. The resident was admitted to the home on an identified date in 2014. The MAR indicated that step one TST was administered 12 days following the admission, however staff interviewed and the clinical documentation confirmed that the results of step one of the test was not read. The MAR indicated that step two TST was administered 19 days following step one TST; however staff interviewed and clinical documentation confirmed that the results of this step of the screening was not read by staff. Results of the screening for this resident was not documented in the clinical record. [s. 229. (10) 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. 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 did not evaluate residents in accordance with evidence-based practices to minimize risk to the resident, where bed rails were used, in relation to the following: [15(a)]
At the time of this inspection staff in the home were unable to provide evidence that when bed rails were used for resident #005, resident #007 and resident #014 that these residents had been assessed and their bed systems evaluated in accordance with evidence-based practices.
-On July 30, 2015 resident #005's bed was noted to be equipped with a full side bed rail on the left side of the bed and a half bed rail on the right side of the bed. The resident's plan of care identified that two bed rails were to be used whenever the resident was in bed. PSWs providing care to the resident confirmed that the bed rails were used whenever the resident was in the bed.
- On July 30, 2014 resident #007's bed was noted to be equipped with one half bed rail on the left side of the bed and a full bed rail on the right side of the bed. The resident's plan of care indicated that bed rails were to be used whenever the resident was in bed. PSWs confirmed that the bed rails were used whenever the resident was in bed.
- On July 30, 2013 resident #014's bed was noted to be equipped with one full bed rail on the right side of the bed and one half bed rails on the left side of the bed. The resident's plan of care indicated that the bed rails were to be used when in bed for safety. PSWs confirmed that the bed rails were used whenever the resident was in bed.
The home provided a Restraint Assessment Form used to assess resident #005 dated November 3, 2011, a Restraint Assessment Form used to assess resident #007 dated December 19, 2011 and a Restraint Assessment Form used to assess resident #014 dated June 4, 2014. The tool the home used to assess these residents and the resident's bed system when a decision to implement the use of bed rails did not incorporate the US Food and Drug Association Guidelines titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, April 2003". The guideline has been endorsed by Health Canada and is currently the only document with comprehensive information regarding bed safety and bed rail use. [s. 15. (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. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that, for each resident demonstrating responsive behaviours the behavioural triggers for the resident were identified, strategies were developed and implemented to respond to these behaviours or actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the residents responses to the interventions were documented in relation to the following: [53(4)(a),(b)and(c)]

1.The licensee did not ensure that behavioural triggers were identified for resident #004, resident #005 and resident #010, in relation to the following: [53(4)(a)]
a. Staff in the home did not attempt to identify triggers for responsive behaviours being demonstrated by resident #004. Clinical documentation confirmed that this resident began demonstrating an identified responsive behaviour when a Resident Assessment Instrument-Minimum Data Set (RIA-MDS) review completed on October 15, 2013 indicated the resident was demonstrating this responsive behaviour and also indicated that the resident's condition was deteriorating. Clinical documentation recorded by Personal Support Workers (PSW) in the Point of Care (POC) computerized record indicated that the resident demonstrated a second responsive behaviour 18 times between July 10, 2014 and August 8, 2014. Behavioural Support Ontario (BSO) staff in the home confirmed that possible triggers for these behaviours were not identified.
b. Staff in the home did not attempt to identify triggers for responsive behaviours being demonstrated by resident #005. Clinical documentation confirmed that this resident demonstrated a responsive behaviour when RAI-MDS reviews completed on May 8, 2013, August 8, 2013, November 8, 2013 and February 8, 2014 indicated that the resident demonstrated this behaviour one to three days out of seven days throughout this

period of time. Behavioural Support Ontario (BSO) staff in the home confirmed that possible triggers for this responsive behaviour were not identified.
c. Staff in the home did not attempt to identify triggers for responsive behaviours being demonstrated by resident #010. Clinical documentation confirmed that resident #010 demonstrated multiple responsive behaviours when RAI-MDS reviews completed on October 1, ~~3013~~ 2013 indicated that resident demonstrated two identified responsive behaviours and on January 1, 2014 when the RAI-MDS review indicated the resident demonstrated three identified responsive behaviours. Documentation completed by PSW in the clinical record between July 13, 2014 and August 10, 2014 indicated the resident demonstrated a newly identified responsive behaviour six times, a second newly identified responsive 13 times and continued to demonstrate three previously identified responsive behaviours during this period of time. Behavioural Support Ontario (BSO) staff in the home confirmed that possible triggers for these responsive behaviour were not identified.

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2. The licensee did not ensure that, for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to the behaviours, in relation to the following:[53(4)(b)]
a) Staff in the home did not develop and implement strategies for behaviours being demonstrated by resident #004. Clinical documentation recorded by PSWs in the Point of Care(POC) computerized record between July 10, 2014 and August 8, 2014 indicated that the resident demonstrated an identified responsive behaviour 18 times and a second identified responsive behaviour once during this period of time. Staff and clinical documentation confirmed that the document used by the home to provide directions for staff providing care to the resident did not identify either of these responsive behaviours as care focuses and did not identify strategies for staff to follow in the management of these behaviours.
b) Staff in the home did not develop and implement strategies for behaviours being demonstrated by resident #010. Clinical documentation recorded by PSWs in POC between July 13, 2014 and August 10, 2014 indicated that the resident demonstrated an identified responsive behaviour six times, a second responsive behaviour 28 times, a third responsive behaviour 13 times, a fourth responsive behaviour once and a fifth responsive behaviour twice during this period of time. Staff and clinical documentation confirmed that the document used by the home to provide directions for staff providing care to the resident did not identify the above documented behaviours as care focuses and did not identify strategies for staff to follow in the management of these behaviours.

3. The licensee did not ensure that, for each resident demonstrating responsive

behaviours, actions are taken including assessment of the behaviours being demonstrated, in relation to the following: [53(4)(c)]
a) Staff in the home did not assess behaviours being demonstrated by resident #004. Clinical documentation recorded by PSWs in POC between July 10 and August 8, 2014 indicated that the resident demonstrated an identified responsive behaviour 18 times and a second responsive behaviour once during this period of time. Staff responsible for overseeing the home's behaviour management program and clinical documentation confirmed that these behaviours were not assessed.
b) Staff in the home did not assess behaviours being demonstrated by resident #010. Clinical documentation recorded by PSWs in POC between July 13, 2014 and August 10, 2014 indicated that the resident demonstrated an identified responsive behaviour six times, a second responsive behaviour 28 times, a third responsive behaviour 13 times, a fourth responsive behaviour once and a fifth responsive behaviour twice during this period of time. Staff responsible for overseeing the home's behaviour management program and clinical documentation confirmed that these behaviours were not assessed. [s. 53. (4)]

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. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
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. O. Reg. 79/10, s. 110 (2).

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:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee did not ensure that staff applied physical devices used to restrain a resident in accordance with the manufacturer's instructions, in relation to the following: [110(1)1]
At the time of this inspection the Director of Care (DOC) provided information from the vendor of the seat belts being used in the home, that confirmed the directions for application where that all seat belts should be applied so that there is just enough space for two fingers to fit between the seat belt and the resident. Three residents were noted to not have seat belts applied according to vendor/manufacturer's directions.

a) Resident #020 did not have a front fastening seat belt applied according to manufacturers. On July 29, 2014 the resident was noted to be sitting in a wheelchair with a front fastening seat belt applied and it was noted that there was a three to four inch gap between the resident's body and the seat belt. A PSW providing care to the resident indicated that the seat belt was not able to be tightened because of the wheelchair. Registered staff confirmed that the seat belt was not properly applied and was too loose.
b) Resident #021 did not have a front fastening seat belt applied according to manufacturer's directions. On July 29, 2014 the resident was noted to be sitting in a wheelchair with a front fastening seat belt applied. It was noted at this time that there was a four to five inch gap between the resident's body and the seat belt. Registered staff confirmed that the seat belt was not applied properly and was too loose.
c) Resident #022 did not have a front fastening seat belt applied according to manufacturer's directions. On July 29, 2014 the resident was noted to be sitting in a wheelchair with a front fastening seat belt applied. It was noted at this time that there was a four to five inch gap between the resident's body and the seat belt. Registered staff confirmed that the seat belt was not properly applied and was too loose. [s. 110. (1) 1.]

2. The licensee did not ensure that staff only applied a physical device used to restraint a resident that had been ordered or approved by a physician or registered nurse in the extended class, in relation to the following: [110(2)1]

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a) On July 30, ~~2015~~ 2014 resident #005 was noted to be sitting in a specialized chair that had been tilted back to a greater that 45 degree angle. A review of the resident's plan of care indicated that the tilted chair was being used as a physical restraint. On this same day it was observed that the resident's bed was equipped with a full side rail on the left side of the bed and a half rail on the right side of the bed and the resident's plan of care identified that two bed rails were to be used as a physical restraint whenever the resident was in bed. Staff and clinical documentation confirmed that there was not an order for the use of a tilted chair or two bed rails currently being used to restrain this resident.
b) On July 30, 2014 resident #007 was noted to be sitting in a wheelchair that had been tilted back to a 45 degree angle and a review of the resident's plan of care indicated that the resident was at risk for falling from sliding out of the chair. On this same day it was observed that the resident's bed was equipped with one half rails on the left side of the bed and a full rail on the right side of the bed. The resident's plan of care indicated the resident was a high risk of falling as a result of climbing from bed and bed rails were being used to manage this risk of falling. Staff and clinical documentation confirmed that there was not an order for the use of the tilted chair or bed side rails currently being used to restraint this resident.

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c) On July 30, ~~2013~~ resident #014 was noted to be sitting in a specialized chair that had been tilted back at a 45 degree angle. Staff interviewed on July 29, 2014 confirmed that the tilted chair was being used to prevent the resident from falling out of the chair. The resident's plan of care indicated that the resident was a high risk for falling due to poor judgement. Staff and clinical documentation confirmed that there was not an order for the use of the tilted chair currently being used to prevent the resident from falling from the chair. [s. 110. (2) 1.]

3. The licensee did not ensure that for all residents who are being restrained, the resident's condition is reassessed and the effectiveness of the restraining evaluated at least every eight hours, in relation to the following: [110(2)6]
Registered staff confirmed that when a resident is being restrained they are to document on the Medication Administration Record (MAR) every shift that the resident's condition has been reassessed and the effectiveness of the restraining has been evaluated.
a) Resident observation and clinical documentation confirmed that resident #005 was restrained by the use of a tilted chair and the use of bed rails in order to manage a risk of falling. Registered staff and the MAR confirmed that staff had not completed a reassessment of the resident's condition and the effectiveness of the restraining devices being used every eight hours.
b) Resident observation and clinical documentation confirmed that resident #007 was restrained by the use of a tilted chair and the use of bed rails in order to manage a risk of falling. Registered staff and the MAR confirmed that staff had not completed a reassessment of the resident's condition and the effectiveness of the restraining devices being used every eight hours.
c) Resident observation and clinical documentation confirmed that resident #014 was restrained by use of a tilted chair in order to manage a risk of falling. Registered staff and the MAR confirmed that staff had not completed a reassessment of the resident's condition and the effectiveness of the restraining devices being used every eight hours. [s. 110. (2) 6.]

4. The licensee did not ensure that for every use of a physical device to restrain a resident documentation related to alternatives to the use of restraints were considered, the order for the restraining device, the consent for the restraining device, the person who applied the restraining device and the time the device was applied, the resident's response to the device and every release of the device and all repositioning was included in the resident's plan of care, in relation to the following: [110 (7)]

a) The licensee did not ensure that there was documentation in the clinical record to

confirm that alternatives to restraints where considered and why those alternatives were inappropriate before applying restraining devices to resident #005, resident #007 and resident #014, in relation to the following: [110(7)2]
1. Resident #005 was restrained by use of two bed rails when in bed and a tilted chair whenever the resident was sitting, in order to manage a risk for falling. At the time of this inspection staff in the home were unable to provide documentation to confirm that alternatives to the use of these devices were tried prior to their application.
2. Resident #007 was restrained by the use of a tilted chair whenever sitting and the use of bed rails when in bed, in order to manage a risk of falling. At the time of this inspection staff in the home were unable to provide documentation that identified that alternatives to the use of these devices were tried prior to their application.
3. Resident #014 was restrained by the use of a tilted chair in order to manage a risk of falling. At the time of this inspection staff in the home were unable to provide documentation that identified that alternatives to the use of a tilted chair were considered prior to the application of the devise.

b) The licensee did not ensure that there was documentation in the clinical record to confirm that consent for the use of restraining devices was obtained prior to the use of restraining devices for resident #007 and resident #014, in relation to the following: [110(7)4]
1. Resident #007 was being restrained by use of a titled wheelchair whenever sitting and two bed rails whenever in bed, in order to manage a risk of falling. At the time of this inspection staff and clinical documentation confirmed that the home did not have consent to apply these devices.
2. Resident #014 was being restrained by use of a tilted chair and two bed rails whenever in bed, in order to manage a risk of falling. At the time of this inspection staff and clinical documentation confirmed that the home did not have consent to apply these devices.

c) The licensee did not ensure that there was documentation in the clinical record that identified the person who applied restraining devices and the time the devices were applied for restraining devices in use for resident#005, resident #007 and resident#014 in relation to the following: [110(7)5]
1. Resident #005 was restrained by use of two bed rails when in bed and a tilted chair whenever the resident was sitting, in order to manage a risk for falling. Staff and clinical documentation confirmed that the person applying these devices and the time the devices were applied is not included in the resident clinical documentation. The DOC confirmed that the documentation format being used in the home does not facilitate staff

documenting this required information.
2. Resident #007 was restrained by the use of a tilted chair whenever sitting and the use of bed rails when in bed, in order to manage a risk of falling. Staff and clinical documentation confirmed that the person applying these devices and the time the devices were applied is not included in the resident clinical documentation. The DOC confirmed that the documentation format being used in the home does not facilitate staff documenting this required information.
3. Resident #014 was restrained by the use of a tilted chair in order to manage a risk of falling. Staff and clinical documentation confirmed that the person applying these devices and the time the devices were applied is not included in the resident clinical documentation. The DOC confirmed that the documentation format being used in the home does not facilitate staff documenting this required information.

d) The licensee did not ensure that there was documentation in the clinical record that identified the resident's response to the restraining devices in place for resident #005, resident#007 and resident #014, in relation to the following: [110(7)6]
1. Resident #005 was restrained by use of two bed rails when in bed and a tilted chair whenever the resident was sitting, in order to manage a risk for falling. Staff and clinical documentation confirmed that the resident's response to being restrained was not documented in the clinical record. The DOC confirmed that the documentation format being used in the home does not facilitate staff documenting this required information.
2. Resident #007 was restrained by the use of a tilted chair whenever sitting and the use of bed rails when in bed, in order to manage a risk of falling. Staff and clinical documentation confirmed that the resident's response to being restrained was not documented in the clinical record. The DOC confirmed that the documentation format being used in the home does not facilitate staff documenting this required information.
3. Resident #014 was restrained by the use of a tilted chair in order to manage a risk of falling. Staff and clinical documentation confirmed that the resident's response to being restrained was not documented in the clinical record. The DOC confirmed that the documentation format being used in the home does not facilitate staff documenting this required information.

e) The licensee did not ensure that there was documentation in the clinical record that identified every release of the restraining devices and all repositioning of the resident for resident #005, resident#007 and resident #014, in relation to the following: [110(7)7]
1. Resident #005 was noted to be restrained by use of a tilted chair and bed rails. There was no documentation in the clinical record related to the application of the tilted chair or the repositioning of the resident while in the tilted chair. Documentation in the

computerized record did not consistently identify when the bed rails were applied or removed when the resident was identified as being in bed.
2. Resident #007 was noted to be restrained by use of a tilted chair and bed rails. Documentation in the clinical record did not identify every release of these devices or when the resident was repositioned when these restraining devices were in use.
3. Resident #014 was noted to be restrained by use of a tilted chair and bed side rails. Documentation in the clinical record used by PSW's did not identify every release of these devices or when the resident was repositioned when these restraining devices were in use. [s. 110. (7)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 and ensure staff comply with O. Reg 79/10, s. 110(1)1, 110(2)1 and 110 (2)6, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (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 did not ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the residents, in relation to the following: [6(1)(c)]

a) Staff and clinical documentation confirmed that resident #024's written plan of care did not provide clear directions to staff when it was noted that the document the home used to provide care directions contained conflicting information with respect to positioning and transfers. Interventions contained in the resident's plan of care related to the management of skin breakdown directed that the resident was to be up in the chair for one hour at breakfast, returned to bed until dinner, up for one hour to eat dinner and then to be transferred into bed. This information conflicted with directions provided to staff and identified in the sleep/wake section of the above noted document. Care directions in the sleep/wake section of the plan were that two staff were to provide total assistance to

transfer the resident to bed after lunch to nap on a daily basis.

b) Staff and clinical documentation confirmed that the written plan of care for resident #012 did not provide clear directions to staff and others who provided direct care to this resident. A Minimum Data Set (MDS) review completed on September 15, 2013 indicated the resident had one pressure ulcer and skin treatments in place over the last seven days. Interventions included; pressure relieving devices for a chair, turning and positioning program, nutrition and hydration interventions, ulcer care and the application of dressings. A statement written in the Activities of Daily Living RAP completed on September 15, 2013 conflicted with the information identified in the MDS review when staff documented that the resident had two pressure ulcers. The Wound Care Coordinator confirmed that at the time of the above noted review, the document the home used to provide care directions to staff did not contain clear directions related to areas of skin breakdown, the application of a pressure relieving device for the resident's chair, directions for staff related to turning and positioning the resident or ulcer care. [s. 6. (1) (c)]

2. The licensee did not ensure that the care set out in the plan of care was based on an assessment of the resident, in relation to the following: [6(2)]

a)Resident #005's plan of care was not based on an assessment of the need for the use of restraints. During the inspection the resident was noted to be sitting in a tilted chair and staff confirmed that the bed rails that were to be applied to the resident's bed were used whenever the resident was in bed. The document used by the home to direct the care of the resident indicated that the resident required the use of bed rails and a tilted chair as restraining devices. At the time of this inspection staff in the home were unable to provide restraint assessments for the use of the tilted chair or the bed rails.
b)Resident #007's plan of care was not based on an assessment of the need for the use of restraints. During this inspection the resident was noted to be sitting in a tilted chair and staff confirmed that the bed rails that were noted to be applied to the resident's bed were used whenever the resident was in bed. The document used by the home to direct the care of the resident indicated that the resident was at risk for falling due to climbing out of bed and sliding from the wheelchair, that bed rails were to be used to prevent falling from bed and a tilted chair was to be used to prevent the resident from falling from the chair. At the time of this inspection staff in the home were unable to provide restraint assessments for the use of the tilted chair or the bed rails.
c) Resident # 014's plan of care was not based on an assessment of the need for the use of restraints. During this inspection the resident was noted to be sitting in a tilted chair

and staff confirmed that the bed rails that were noted to be applied to the resident's bed were used whenever the resident was in bed. The document used by the home to direct the care of the resident indicated that the resident was at risk for falling due to dementia and poor judgement, staff were to check the resident every hour during periods where the risk for falls was high and one full bed rail and one half bed rail were to be applied for bed safety. At the time of this inspection staff in the home were unable to provide restraint assessments for the use of the tilted chair or the bed rails. [s. 6. (2)]

3. The licensee did not ensure that the care set out in the plan of care for resident #024 was provided to the resident as specified in the plan of care, in relation to the following: [6(7)]
Resident #024's plan of care directed that the resident was to be up in the chair for one hour at breakfast, returned to bed until dinner, up for one hour during the dinner meal and then was to return to bed. This direction was revised on July 28, 2014 as an intervention to manage current and ongoing skin breakdown. On August 8, 2014 staff providing care confirmed that the resident was transferred into a chair at 0800hrs and remained in the chair until after 1255hrs. The resident's plan of care also directed that staff were to reposition the resident every two hours and the resident was to be off particularly bony prominences. This care was not provided on August 8, 2014 when the resident was monitored for a period of time in excess of two hours and it was noted that the resident's position in the chair had not changed and the resident was positioning poorly in a specialized chair sitting predominantly on the right hip during this period of time. [s. 6. (7)]

4. The licensee did not ensure that all residents were reassessed and their plans of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or the care set out in the plan has not been effective. [6(10)]

a) The licensee did not ensure that resident #005 and resident #007 were reassessed and their plans of care reviewed and revised at least every six months, in relation to the following:

i) Resident #005 was not reassessed in relation to the use of physical restraints for a period of time in excess of six months. The resident's plan of care indicated that the resident was being restrained with the use of a tilted chair when the resident is sitting and the use of two bed rails whenever the resident is in bed. Clinical documentation indicated that these interventions identified to manage a risk for falling where implemented on June 2, 2011 and August 30, 2011 respectively. Minimum Data Set (MDS) reviews completed

on November 8, 2013, February 8, 2014 and May 9, 2014 indicated that the use of restraints for this resident was not triggered and a reassessment of the use of these restraining devices was not completed over this seven month period. A review of the resident's clinical record indicated that there were no restraint assessments completed during the above noted period of time.

ii) Resident #007 was not reassessed in relation to the use of physical restraints for a period of time in excess of six months. The resident's plan of care indicated that the resident was being restrained by use of a bed rail when in bed and a tilted chair when sitting as interventions to manage a risk of falling due to failure of the resident to recognize limitations, climbing out of bed and falling from the chair. Clinical documentation indicated that these interventions where implemented on May 23, 2012 and June 16, 2010 respectively. MDS reviews completed on September 1, 2013, December 1, 2013, March 14, 2014 and June 1, 2014 indicated the use of restraints for this resident was not triggered and a reassessment of the use of these restraining devices was not completed over this 10 month period of time. A review of the resident's clinical record indicated that there were no restraint assessments completed during the above noted period of time. (129)

b)The licensee did not ensure that Residents #010, #009 and #005 were reassessed and their continence plans of care reviewed and revised at least every six months and at any other time when the residents' care needs changed or care was no longer effective in relation to the following: [6(10)(b)]

i) Resident #010 was observed on July 24, July 31 and August 5, 2014 and the Inspector noted an odour of urine. The resident's MDS for continence, completed on October 1, 2013, indicated that the resident experienced a deterioration in urinary continence. A review of assessment and plan of care records confirmed that staff had not completed a urinary continence assessment for the resident on admission on an identified date in December 2012, after urinary continence deterioration in October, 2013 or at any other time, including when care provided was no longer effective. The resident's continence plan of care had not been revised since its creation on January 30, 2013. The Assistant Director of Care (ADOC) confirmed that the resident was not reassessed when their care needs changed, or at any other time, over an 18 month period of time. The ADOC further confirmed that the resident's plan of care had not been revised to reflect a change in condition.

ii) Clinical records for Resident #009 were reviewed and the Minimum Data Set (MDS)

for continence, completed on August 1, 2013, indicated that the resident experienced a deterioration in urinary continence. A review of assessment and plan of care records confirmed that staff had not complete a urinary continence assessment or revise the resident's continence plan of care since January 27, 2012. The Assistant Director of Care (ADOC) confirmed that the resident was not reassessed when their care needs changed, or at any other time, over a 30 month period of time. The ADOC further confirmed that the resident's plan of care had not been revised to reflect a change in condition.

iii) Resident #005 was observed on July 24 and Aug 5, 2014 and the Inspector noted an odour of urine. A review of assessment and plan of care records confirmed that staff had not complete a urinary continence assessment or revise the resident's continence plan of care since January 25, 2012. Staff interviews indicated that the resident was often resistive to care, making it difficult for staff to provide continence care as specified on the resident's plan of care. The Assistant Director of Care (ADOC) confirmed that the resident was not reassessed for urinary incontinence over a 30 month period of time. The ADOC further confirmed that the resident's plan of care had not been revised.(584)

c) The licensee did not ensure that Resident #002 was reassessed and the plan of care revised at any time when the care set out in the plan has not been effective, in relation to the following: [6(10)(c)]

The clinical records for Resident #002 were reviewed and it was noted that the resident experienced ongoing constipation and consumed diuretics, placing the resident at heightened dehydration risk. A hydration intervention was created by the Registered Dietitian (RD) of the home on June 4, 2013 instructing staff to provide 60 millilitres of water at noon and evening medication pass. Information collected on admission to the home indicated that ~~there~~ this intervention may not be appropriate for the resident. Interview with the RD revealed that the RD was not aware of this information. Staff indicated that this intervention was not appropriate for this resident. The RD confirmed that the resident was not receptive to the intervention created a year ago and the plan of care was not reviewed or revised to reflect this. [s. 6. (10)]

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Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 and ensuring that staff comply with LTCH Act, 2007, c. 8, s 6(1)(c) and 6(2), to be implemented voluntarily.

WN #6: 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 did not ensure that where the Act or this Regulation requires the licensee to have , institute or otherwise put in place any plan, policy or protocol that the plan, policy or protocol was complied with, in relation to the following: [8(1)(b)]

a) Skin and Wound Care Policies
i) The home's policy [Skin Care Program Overview] identified as #03-01 and dated June 2010 was not complied with when directions related to care staff receiving annual education in preventive of skin care as well as wound care for Registered staff were not followed. Information provided by the home confirmed that this policy was not complied with when it was identified that 155 care staff out of 172 care staff did not receive education and training in preventive skin care in 2013.
ii) The home's policy [Skin Care Committee] identified as #03-02 and dated April 2010 was not complied with when directions that the Skin Care Committee will annually evaluate the skin care program using the template attached to the policy and develop

action plans where required based on the annual evaluation were not followed. The Administrator confirmed that this policy was not complied with when the 2013 evaluation of the Skin and Wound Program was not completed.
iii) The home's policy [Wound Care Record] identified as # 03-09 and dated June 2010 was not complied with when directions that the Wound Care Record was to be completed weekly were not followed. Staff and clinical records confirmed that this policy was not complied with when Wound Care Records were not completed weekly for resident #012 who was identified to have multiple staged wounds.

b) Infection Control Policy
i) The home's policy [Resident TB Testing] identified as # INFE-02-01-05 and dated February 2014 was not complied with directions related to the requirements for Tuberculosis screening where not followed. Staff and clinical documentation confirmed that resident #025, resident #026 and resident #027 did not receive screening for tuberculosis as identified in this policy.

c) Staff Education (Nutrition)
i)The policy named "Staff Education", #03-05-03, created in April, 2010, specifies mandatory annual educational requirements for dietary staff in the areas of: food storage, handling and preparation; pleasurable dining; sanitation; and therapeutic diets and menu.

Record reviews and interviews with dietary staff and the Nutrition Manager (NM) confirmed that staff did not receive the mandatory annual dietary training as specified in the policy in 2011 and 2013. (584)

d) Communication and Response System Policy
The policy named "Communication Systems", #RESI-08-02-01, reviewed December, 2012, directs registered and care staff to: ensure that call bells at resident's bedside are accessible at all times; check call system every shift to ensure that it remains operational; and report non-functional bells to maintenance for immediate repair.

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i) Observations of Resident #004 and on ~~July 24~~ July 24, 2014 revealed that the residents had a bedside call bell that was difficult to push and a broken bathroom call bell that was inaccessible from the toilet. Interview with the Maintenance Supervisor (MS) in the resident's room on August 5, 2014 confirmed that both call bells required immediate repair because both were not easily accessible of functional. The MS confirmed being unaware of the resident's non-operational call system due to not being informed by staff.

Staff on all shifts during the 12 days did not ensure that the resident's call bells at bedside and in the bathroom were accessible or operational and did not fill out a maintenance report as per policy.

ii) Observations of Resident #010 on July 28, 2014 revealed that the resident had a broken bathroom call bell that was not easily accessible. Interview with the MS in the resident's room on August 5, 2014 confirmed that the call bell required immediate repair because it was not easily accessible. The MS confirmed being unaware of the resident's non-operational call system due to not being informed by staff. Staff on all shifts during the nine days did not ensure that the resident's bathroom call bell was accessible or operational and did not fill out a maintenance report as per policy. (584)

e) Continence Care Management
The policies named "Continence Care Management", #RESI-10-04-01, effective November, 2013, and prior policy "Continence Assessment", #RESI-05-04-01, effective March, 2012, specify that:
1. A continence assessment must be completed upon the resident's admission and with changes in continence.
2. Individual plans of care for continence must be created and revised at least every three months and as a resident's status changes. The plan must identify: a resident's elimination patterns, level and type of incontinence, assistance required, the resident's method of communicating the need to eliminate, equipment or continence products required and the sizing (if applicable), individualized toileting routine and participation in toileting program (if applicable).
3. Residents, family members and staff must have a formal opportunity to express their satisfaction with the range and types of incontinence products used via an annual survey and that the survey results must be considered when making purchasing decisions.

i) Clinical records for Resident #005, #009 and #010 were reviewed. Staff did not complete continence assessment for Resident #010, as per policy, on admission in December of 2012, after deterioration in continence level in October of 2013, or at any other time, for 18 months. Staff did not complete continence assessments for Resident #009, as per policy, after deterioration in continence level in August of 2013, or at any other time, for 30 months. Resident #009 and #010 were observed to smell of urine during inspection.

Staff did not complete continence assessments for Resident #005, as per policy, for 30 months. The Assistant Director of Care (ADOC) confirmed the non-compliance with

policy in relation to continence care assessments for the three residents.

ii) Residents #005, #009 and #010 did not have individualized plans of care identifying all aspects of urinary continence care as per policy. Staff had not revised plans of care for continence for Resident #9 and Resident #5 for 30 months. Staff had not revised plans of care for continence for Resident #10 and Resident #9 after deterioration in continence levels. Staff had not completed a urinary continence assessment for Resident #10 on admission. The ADOC confirmed the non-compliance with policy in relation to continence plans of care for the three residents.

iii) The Director of Care (DOC) and the ADOC could not provide records of the 2013 annual survey distributed to residents, resident families and staff to monitor satisfaction with continence products used in the home. The DOC and ADOC could not provide records of the 2012 annual survey distributed to residents and resident families. The DOC and ADOC confirmed the survey was not completed as per policy.(584) [s. 8. (1) (a),s. 8. (1) (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 and ensuring that where the Act or the Regulation requires the licensee to have, institute or otherwise put in place any plan, policy or protocol that the plan, policy or protocol is complied with, to be implemented voluntarily.

WN #7: 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 did not ensure that resident-staff communication and response system can be easily accessed and used by Resident #004 and Resident #010 at all times.[17(1)(a)]

A) Observation of Resident #004's room on July 24, 2014 revealed that the resident's bathroom call bell was broken and thus not accessible to the resident from the toilet. The bedroom call bell was difficult for the resident to push. Interview with the Maintenance Supervisor (MS) in the resident's room on August 5, 2014 confirmed that the bathroom call bell was not accessible and the bedroom call bell could not be used easily. Resident #004 did not have easy access or use of both call bells in the resident's room for 12 days during the inspection.

B) Observation of Resident #010's room on July 28, 2014 revealed that the resident's bathroom call bell was broken and thus not easily accessible. Interview with the MS in the resident's room on August 5, 2014 confirmed that the bathroom call bell was not easily accessible to the resident. Resident #010 did not have easy access or use of the bathroom call bell. [s. 17. (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 and ensuring that the resident-staff communication and response system can be easily accessed and used, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee did not ensure that staff complied with the written policy to minimize the restraining of residents, in relation to the following: [29(1) (b)]
The home provided three policies related to restraint use that included [Physical Restraints] identified as RESI-10-10-01 and dated November 2012, [Physical Restraint Monitoring] identified as RESI-10-01-04 and dated November 2012 and [Consent for Restraint Use] identified as RESI-10-01-03 and dated November 2012. Staff did not comply with directions contained in these policy related to resident #005, resident #007, resident #014, resident #020, resident #021 and resident #022.
1. The home's policy [Physical Restraints] identified as #RESI-10-10-01 and dated November 2012 provided the following directions:
a) The policy directed that an order for restraint use and a signed consent will be completed on all restraints. Staff did not comply with this direction when staff and the clinical record confirmed that there were not current orders for the restraining devices being use for resident #005, there were not current orders for the restraining devices being used for resident #007, there was not a consent for the restraining devices being used for resident #005 and there was not a consent for the restraining devices being used for resident #014.

b) The policy directed that regular assessments shall be ongoing to trigger opportunities for restraint reductions. Staff did not comply with this direction when there were not regular assessments of the ongoing need for the restraining devices being used for resident #005, resident #007 and resident #014.
c) The policy directed that a restraint assessment will be completed. Staff did not comply with this direction when staff and clinical records confirmed that there were not restraint assessments completed for resident #005, resident #007 and resident #014.
d) The policy directed that alternatives to restraints are to be tried, evaluated and documented. Staff did not comply with this direction when staff and clinical documentation confirmed that alternatives to restraints being used for resident #005, resident #007 and resident #014 were not tried.
e) The policy directed that staff were to ensure the Restraint Record was completed with hourly safety checks and two hourly position changes which require the release of the restraint and documentation. Staff did not comply with this policy when they did not complete this documentation for resident #005, resident #007 or resident #014 when staff and clinical documentation indicated these residents were being restrained.
f) The policy directed that at a minimum, the resident's response to the restraint and the need for continued use of the restraint must be evaluated each shift and documented. Staff and clinical documentation confirmed that there was no documentation that identified the resident's response to the restraint or the continuing need for the restraints being used for resident #005, resident #007 or resident #014
g) The policy directed that restraint reassessment shall be completed at a minimum quarterly. Staff did not comply with this direction when clinical documentation confirmed that there were not quarterly reviews of the restraints being used for resident #005, resident #007 or resident #014.

2. The home's policy [Physical Restraint Monitoring] identified as # RESI-1001-04 and dated November 2012 provided the following direction:
a) For homes that utilize the electronic documentation for the PSW/HCA's the task for physical restraint in Point Click Care (PCC) will be opened by the registered staff and individualized to the resident. Staff in the home did not comply with this direction when the task for physical restraints in PCC was not opened for resident #005 related to the use of the tilted chair, for resident #007 related to the use of the tilted chair or the use of bed rails or for resident #014 related to the use of the tilted chair or the bed rails. [s. 29. (1) (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 and ensuring that staff comply with the written policy to minimize the restraining of residents, to be implemented voluntarily.

WN #9: 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 did not ensure that each of the organized programs required under sections 8 to 16 of the Act, specifically the Continence Care and Skin and Wound programs, were evaluated and updated at least annually. [30(1)3]

a) The Director of Care (DOC) and Assistant Director of Care (ADOC) confirmed that annual evaluations of the continence care program did not occur in 2013. (584)

b)The Administrator confirmed that the home did not complete an evaluation of the home's Skin and Wound Care program for 2013. (129) [s. 30. (1) 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 and ensuring that the organized programs required under sections 8 to 16 of the Act are evaluated and updated at least annually, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that a resident at risk for altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, in relation to the following: [50(2)(b)(iv)]

Resident #012 was identified as having altered skin integrity when staff documented on a skin and wound assessment completed in August 2013 that the resident had a wound. Staff and clinical documentation confirmed that registered staff did not document weekly reassessments for this resident. Following the above noted assessment the clinical record indicated that the resident was assessed the following week 14 days later, 36 days later, seven days later, 13 days later where it was identified that the resident continues to have areas of skin breakdown identified in the previous assessments and it was identified on this assessment that the resident had an additional area of skin breakdown. Documentation indicated that the resident was next reassessed 72 days later on when staff indicated that the resident had a new area of skin breakdown as well as an existing area of skin breakdown. [s. 50. (2) (b) (iv)]

2. The licensee did not ensure that resident #024, who is dependent on staff for repositioning was repositioned every two hours, in relation to the following: [50(2) (d)]

Staff and clinical documentation confirmed that resident #024 was totally dependent on two staff for all aspects of positioning and the resident had ongoing areas of skin breakdown. On August 8, 2014 this resident was not repositioned for a period of time in excess of two hours. The resident was monitored at 1045hrs. and noted to be sitting in a specialized chair that was placed beside the resident's bed. The chair had been tilted backwards to a greater than 45 degree angle, the resident was noted to be poorly positioned in the chair with the resident's weight on the right hip, the resident's knees were flexed and their feet resting on a metal bar. At 1145hrs the resident was noted to be sitting in the same position in the same location. At 1255hrs the resident was noted to be sitting in the specialized chair in the dining room, the tilt position of the chair had changed, however the resident's position in the chair had not changed and the resident continued to be sitting in the same position in the chair with the resident's weight on the right hip and their feet resting on the metal bar. [s. 50. (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 and ensuring that staff comply with O. Reg. 79/10 50(2)(b)(iv) and 50(2)(d), to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee did not ensure that concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

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The Resident's Council advised the home of concerns at each of their meetings on January 21, 2014, March 18, 2014, April 15, 2014 and May 20, 2014 and they were not responded to in writing within ten days of receiving. The written responses ~~where~~ were provided and addressed at the subsequent monthly meetings. The President of the Resident's Council confirmed they did not receive the written responses to the residents concerns until their meeting the next month. The home's Residents' Council assistant and the Administrator confirmed the written responses are provided to the Resident's Council at the next monthly meeting. [s. 57. (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 and ensuring a written response is provided within 10 days of receiving advice from Resident's, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

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

Findings/Faits saillants :

1. The licensee did not ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, annual training in accordance with O. Reg. 219, in how to minimize the restraining of residents and, where retraining is necessary, how to do so in accordance with the Act and the regulations, in relation to the following: [76(7) 4]
Information provided by the home indicated that 150 of 172 staff who provided direct care to residents in 2013 did not receive annual training related to minimizing the restraining of residents. [s. 76. (4)]

2. The licensee did not ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training related to skin and wound care, in accordance with O. Reg. 79/10 s. 221(1) 2, in relation to the following: [76(7) 6]
A)Information provided by the home at the time of this inspection indicated that 155 of 172 staff who provided direct care to residents in 2013 did not receive annual training in accordance with O. Reg. 70/10 s. 219(1) and 221(1) 2 and 3, in the area of skin and wound care. (129)
B) Information provided by the home at the time of this inspection indicated that 140 of 172 staff who provided direct care to residents in 2013 did not receive annual training in accordance with O. Reg. 70/10 s. 219(1) and 221(1) 3, in the area of continence care. (584) [s. 76. (7) 6.]

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 and ensuring that annual training is provided to all staff who provide direct care to residents in the areas of skin and wound care and continence care, to be implemented voluntarily.

WN #13: 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. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee did not seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results, in relation to the following: [85(3)]

a) The President of the Resident's Council confirmed that the licensee did not seek the advice of the Residents' Council in developing and carrying out the survey, and in acting on its results. The Residents' Council meeting minutes were reviewed for each month in 2013 and 2014, there was no documentation related to the licensee seeking the advice of the Residents' Council in developing and carrying out the survey, and in acting on its results. The Administrator and the Assistant to the Residents' Council confirmed that the home did not seek out the advice of the Residents' Council in developing and carrying out the survey, and in acting on its results.
b) The President and a representative of the Family Council advised that the home did not seek the advice of the members in developing and carrying out the home's satisfaction survey, and in acting on its results. They confirmed they are aware of the survey, however they have not provided any advice to the home and the home has not

sought out their advice. The Administrator confirmed they did not seek out the advice of the Family Council members in developing and carrying out the survey, and in acting on its results. [s. 85. (3)]

2. The licensee did not ensure that, (a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); (b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; (c) the documentation required by clauses (a) and (b) is made available to residents and their families; and (d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX, in relation to the following: [85(4)(a)(b)(c)]

The President of the Residents' Council was interviewed on July 30, 2014 and August 1, 2014. The President was not aware of the home's satisfaction survey results, where the documentation of the results were located, and the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey. Based on the review of the Residents' Council meeting minutes for 2013 and 2014 there was no minutes of the licensee seeking the advice of the Residents' Council related to the home's satisfaction survey results, or the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey, or documentation of the home's satisfaction survey results. The Administrator and the Assistant to the Residents' Council confirmed the home did not ensure that the results of the survey were made available to the Residents' Council, the home did not seek their advice, the home did not make available the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey.
b)The President of the Family Council and a member of the Council was interviewed on July 30, 2014 and August 1, 2014. The President and Council member was not aware of the home's satisfaction survey results, where the documentation of the results were located, and the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey. Based on the review of the Family Council meeting minutes for 2013 and 2014 there was no minutes of the licensee seeking the advice of the Family Council related to the home's satisfaction survey results, or the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey, or documentation of the home's satisfaction survey results. The Administrator confirmed the home did not

ensure that the results of the survey were made available to the Family Council, the home did not seek their advice, the home did not make available the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey. [s. 85. (4) (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 and ensuring that the advise of Residents' Council and Family Council is sought in the developing and carrying out the a satisfaction survey, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 79/10, s. 24 (1).

Findings/Faits saillants :

1. The licensee did not ensure that a 24-hour admission care plan was developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home, in relation to the following: [24(1)]
Resident # 023 was admitted to the home on an identified date in 2014 and at the time of the admission the resident was assessed as having two pressure ulcers. Staff and clinical documentation confirmed that a care plan was not developed within 24 hours of the resident being admitted to the home and care directions to staff where not provided to staff in relation to the management of altered skin integrity until three months after the admission. [s. 24. (1)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

Findings/Faits saillants :

1. The licensee did not ensure that an evaluation of residents' satisfaction with the range of continence care products in consultation with the residents, substitute decision-makers and direct care staff was completed in 2013, in relation to the following: [51(1)5]

At the time of this inspection the Director of Care (DOC) and the Assistant Director of Care (ADOC) could not provide records of the 2013 annual continence product satisfaction survey distributed to residents, resident families and staff. The DOC and ADOC could not provide records of the 2012 annual survey distributed to residents and resident families. The DOC and ADOC confirmed the survey was not completed. [s. 51. (1) 5.]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. The licensee did not ensure that consultation occurred with the Residents' Council at least every three months.

a) The President of the Residents' Council advised that the home does not consult with them at least every three months. The representatives were not able to provide any information related to consultation by the home. The Administrator confirmed that consultation with the Residents' Council has not occurred at least every three months.
b) The President of the Family Council advised that the home does not consult with them at least every three months. The Family Council representatives were not able to provide any information related to consultation by the home. In reviewing the Family Council meeting minutes that are available, there was no consultation noted by the home with the Family Council. The Administrator confirmed that consultation with the Family Council has not occurred at least every three months. [s. 67.]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Findings/Faits saillants :

1. The licensee did not ensure that the copy of the service accountability agreement, as defined in section 21 of the Commitment to the Future of Medicare Act, 2004, entered into between the licensee and the local health integration network (LHIN), was posted in the home in a manner specified under s. 79 of the Act.

A review of the entrance conference Long Term Care Home Licensee Confirmation Checklist and an interview with the Administrator of the home confirmed that the service accountability agreement was not posted as required under LTCHA s. 79 (3). (g.1) [s. 79.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information

Specifically failed to comply with the following:

s. 225. (1) For the purposes of clause 79 (3) (q) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following:
1. The fundamental principle set out in section 1 of the Act. O. Reg. 79/10, s. 225 (1).
2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 101 (3) of the Act. O. Reg. 79/10, s. 225 (1).
3. The most recent audited report provided for in clause 243 (1) (a). O. Reg. 79/10, s. 225 (1).
4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 225 (1).
5. Together with the explanation required under clause 79 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act. O. Reg. 79/10, s. 225 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the most recent audited reconciliation report was posted in the home in a manner that complies with s. 79 of the Act, in relation to the following: [225(1)3]

A review of the entrance conference Long Term Care Homes Licensee Confirmation Checklist and an interview with the Administrator of the home confirmed that the most recent reconciliation report was not posted. [s. 225. (1) 3.]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 27th day of February, 2015

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

Phyllis Hiltz-Bontje

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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) :	PHYLLIS HILTZ-BONTJE (129), KATHLEEN MILLAR (527), VIKTORIA SHIHAB (584)
Inspection No. / No de l'inspection :	2014_205129_0017
Log No. / Registre no:	H-000954-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 25, 2015
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE HALTON HILLS 9 Lindsay Court, Georgetown, ON, L7G-6G9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ANDRE' SPEKKENS

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
O. Reg. 79/10, s. 229 (10).

Order / Ordre :

The licensee shall ensure that all current residents and all residents admitted to the home are screened for tuberculosis in accordance with the directions provided by Halton Regional Health Department.

Grounds / Motifs :

Error Feb 27/15 @ 1:10pm PHB

1. Three of three residents reviewed were not screened for tuberculosis in accordance with the directions from Halton Region Health Department and contained in the home's policy.
2. The staff member who co-ordinates the infection prevention and control program in the home confirmed that the home followed the "Tuberculosis Screening Recommendations for Long –Term Care Homes" provided by the Halton Region Health Department. Included in the recommendations were directions that a person with unknown tuberculin skin test (TST) must have a

two-step TST. The Halton Region Health Department recommendations were included in the home's infection control manual.
a) Resident #025 did not receive complete screening for tuberculosis. The resident was admitted to the home on an identified date in 2014, staff interviewed and clinical documentation confirmed that step one TST was administered two days following admission; however, there was no indication in the clinical record that the results of this test were read by staff. Staff interviewed and the Medication Administration Record (MAR) indicated that step two TST was administered 17 days following step one TST; however, there was no indication in the clinical record that the results of this test were read by staff. Although the serum was administered to resident #025 there was no indication of the outcome of this screening for tuberculosis.
b) Resident #026 did not receive complete screening for tuberculosis. The resident was admitted to the home on an identified date in 2014. Information provided on admission to the home indicated that the resident received step one TST prior to admission and the results of this step of the screening were negative. Staff interviewed and clinical documentation confirmed that the resident did not receive complete screening for tuberculosis when step two TST was not administered to the resident.
c) Resident #027 did not receive complete screening for tuberculosis. The resident was admitted to the home on an identified date in 2014. The MAR indicated that step one TST was administered 12 days following admission, however staff interviewed and the clinical documentation confirmed that the results of step one of the test were not read. The MAR indicated that step two TST was administered 19 days following step one TST; however staff interviewed and clinical documentation confirmed that the results of this step of the screening were not read by staff. There is no indication in the clinical record of the results of the tuberculosis screening process.

(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 23, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that when bed rails are used the resident is assessed and his or her bed system is evaluated, including resident #005, resident #007 and resident #014, in accordance with evidenced-based practices in order to minimize the risk to the resident.
The plan is to include, but is not limited to:
a) identification of all residents in the home who are using bed rails.
b) a schedule of staff training related to assessing residents who are using bed rails in accordance with evidence based practices.
c) a schedule for the completion of assessments for all residents who are using bed rails.
d) a process for monitoring staff's performance in assessing residents who begin using bed rails.
The plan is to be submitted to Phyllis Hiltz-Bontje by e-mail at Phyllis.Hiltzbontje@Ontario.ca on or before March 16, 2015.

Grounds / Motifs :

1. Three of three residents who staff confirmed where using bed rails were not assessed in accordance with evidenced based practices.
2. At the time of this inspection staff in the home were unable to provide evidence that when bed rails were used for resident #005, resident #007 and resident #014 that these residents had been assessed and their bed systems evaluated in accordance with evidence-based practices.
-On July 30, 2015 resident #005's bed was noted to be equipped with a full side bed rail on the left side of the bed and a half bed rail on the right side of the bed. The resident's plan of care identified that two bed rails were to be used whenever the resident was in bed. PSWs providing care to the resident confirmed that the bed rails were used whenever the resident was in the bed.
- On July 30, 2014 resident #007's bed was noted to be equipped with one half bed rail on the left side of the bed and a full bed rail on the right side of the bed. The resident's plan of care indicated that bed rails were to be used whenever the resident was in bed. PSWs confirmed that the bed rails were used whenever the resident was in bed.
- On July 30, 2013 resident #014's bed was noted to be equipped with one full bed rail on the right side of the bed and one half bed rails on the left side of the bed. The resident's plan of care indicated that the bed rails were to be used when in bed for safety. PSWs confirmed that the bed rails were used whenever the resident was in bed.
3. The home provided a Restraint Assessment Form used to assess resident #005 dated November 3, 2011, a Restraint Assessment Form used to assess resident #007 dated December 19, 2011 and a Restraint Assessment Form used to assess resident #014 dated June 4, 2014. The tool the home used to assess these residents and the resident's bed system when a decision to implement the use of bed rails did not incorporate the US Food and Drug Association Guidelines titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, April 2003". The guideline has been endorsed by Health Canada and is currently the only document with comprehensive information regarding bed safety and bed rail use. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 30, 2015

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that for each resident demonstrating responsive behaviours, including resident #004, resident #005 and resident #010 that behavioural triggers are identified, strategies are developed and implemented to respond those behaviours and actions taken to respond to the residents, including, assessments and reassessment.
The plan is to include, but is not limited to:
a) The development and implementation of a tool and a specific process to collect data related to responsive behaviours being demonstrated by residents to ensure that staff are able to identify possible triggers for those behaviours.
b) The implementation of a process to ensure resident specific care interventions to manage behavioural triggers identified.
c) A process and schedule for the reassessment of residents demonstrating responsive behaviours.
d) The development and implementation of a staff training program related to the tools, processes, care interventions and reassessment protocols for residents demonstrating responsive behaviours.
e) A method and schedule for monitoring staff's performance related to the identification of behavioural triggers, the development of specific care interventions to manage behaviours and the reassessment of resident's demonstrating responsive.

The plan is to be submitted to Phyllis Hiltz-Bontje by email at Phyllis.Hiltzbontje@Ontario.ca on or before March 16, 2015

Grounds / Motifs :

1. Three of three residents reviewed who were demonstrating responsive behaviours did not have care provided as is required.

2. Staff did not attempt to identify behavioural triggers for three of three residents who demonstrating responsive behaviours. [53(4)(a)]
a. Staff in the home did not attempt to identify triggers for responsive behaviours being demonstrated by resident #004. Clinical documentation confirmed that this resident began demonstrating an identified responsive behaviour when a Resident Assessment Instrument-Minimum Data Set (RIA-MDS) review completed on October 15, 2013 indicated the resident was demonstrating this responsive behaviour and that the behaviour was worsening from previous assessments. Clinical documentation recorded by Personal Support Workers (PSW) in the Point of Care (POC) computerized record indicated that the resident demonstrated a second responsive behaviour 18 times between July

10, 2014 and August 8, 2014. Behavioural Support Ontario (BSO) staff in the home confirmed that possible behavioural triggers for the resistive behaviour or the socially inappropriate behaviour were not identified.
b. Staff in the home did not attempt to identify triggers for responsive behaviours being demonstrated by resident #005. Clinical documentation confirmed that this resident demonstrated an identified responsive behaviour when RIA-MDS reviews completed on May 8, 2013, August 8, 2013, November 8, 2013 and February 8, 2014 indicated that the resident demonstrated this behaviour one to three days out of seven days throughout this period of time. Behavioural Support Ontario (BSO) staff in the home confirmed that possible behavioural triggers for this responsive behaviour were not identified.
c. Staff in the home did not attempt to identify triggers for responsive behaviours being demonstrated by resident #010. Clinical documentation confirmed that resident #010 demonstrated multiple responsive behaviours when RAI-MDS reviews completed on October 1, ~~3013~~ 2013 indicated that resident demonstrated two identified responsive behaviours, and on January 1, 2014 when the RIA-MDS review indicated the resident demonstrated three identified responsive behaviours. Documentation completed by PSW in the clinical record between July 13, 2014 and August 10, 2014 indicated the resident demonstrated a newly identified responsive behaviour six times, a second newly identified responsive behaviour 13 times and continued to demonstrate three previously identified responsive behaviours during this period of time. Behavioural Support Ontario (BSO) staff in the home confirmed that possible behavioural triggers the physically abusive, resistance to care, socially inappropriate, persistent anger and verbally abusive behaviours were not identified.

Error Feb. 27/15 @ 1252pm PHB

3. Staff did not develop and implement strategies for the management of responsive behaviours being demonstrated by two of three residents reviewed. [53(4)(b)]
a)Staff in the home did not develop and implement strategies for behaviours being demonstrated by resident #004. Clinical documentation recorded by PSWs in the Point of Care (POC) computerized record between July 10, 2014 and August 8, 2014 indicated that the resident demonstrated an identified responsive behaviour 18 times and a second responsive behaviour once during this period of time. Staff and clinical documentation confirmed that the document used by the home to provide directions for staff providing care to the resident did not identify either of these identified responsive behaviours as care focuses and did not identify strategies for staff to follow in the management of these behaviours.

b) Staff in the home did not develop and implement strategies for behaviours being demonstrated by resident #010. Clinical documentation recorded by PSWs in POC between July 13, 2014 and August 10, 2014 indicated that the resident demonstrated an identified responsive behaviour six times, a second identified responsive behaviour 28 times, a third identified responsive behaviour 13 times, a fourth responsive behaviour once and a fifth identified responsive behaviour twice during this period of time. Staff and clinical documentation confirmed that the document used by the home to provide directions for staff providing care to the resident did not identify the above documented behaviours as care focuses and did not identify strategies for staff to follow in the management of these behaviours.

4. Staff did not ensure that actions were taken including assessment and reassessment for two of three residents who were identified as demonstrating responsive behaviours. [53(4)(c)]
a) Staff in the home did not assess behaviours being demonstrated by resident #004. Clinical documentation recorded by PSWs in POC between July 10 and August 8, 2014 indicated that the resident demonstrated an identified responsive behaviour 18 times and a second identified responsive behaviour once during this period of time. Staff responsible for overseeing the home's behaviour management program and clinical documentation confirmed that these behaviours were not assessed.
b) Staff in the home did not assess behaviours being demonstrated by resident #010. Clinical documentation recorded by PSWs in POC between July 13, 2014 and August 10, 2014 indicated that the resident demonstrated an identified responsive behaviour six times, a second identified responsive behaviour 28 times, a third identified responsive behaviour 13 times, a fourth responsive behaviour once and a fifth identified responsive behaviour twice during this period of time. Staff responsible for overseeing the home's behaviour management program and clinical documentation confirmed that these behaviours were not assessed. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 13, 2015

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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:

1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that for every use of a physical device to restrain a resident the following are documented in the resident's clinical record:
- alternatives that were considered and why those alternatives were inappropriate
- consent for the use of the device
-the person who applied the device and the time of application
- all assessments, reassessments and monitoring, including the resident's response.
- every release of the device and all repositioning

The plan is to include, but is not limited to the following:
1. The development and implementation of a process and schedule to review all resident's in the home who may be in potential restraints to ensure the above noted requirements are documented in the clinical record.
2, The development and implementation of a training program for staff related to Restraints and Minimizing the restraining of residents.
3. The development and implementation of a process for monitoring staff's performance related to the requirement to document the above noted items when physical devices are used to restrain residents.

The Plan is to be submitted to Phyllis Hiltz-Bontje, by e-mail at Phyllis.Hiltzbontje@Ontario.ca on or before march 16, 2015.

Grounds / Motifs :

1. Three of three residents reviewed who were being restrained by the use of physical devices did not have the required information documented in their clinical records related to alternatives to restraints, consent for the use of the devices, the person applying the device and the time of the application, all assessments and reassessments related to restraining as well as every release of the device and all repositioning.

2. Resident # 005, #007 and #014 were noted to be restrained by the use of physical devices and there was no documentation in the clinical record to confirm that alternatives to restraints where considered and why those alternatives were inappropriate before applying restraining device.
a) Resident #005 was restrained by use of two bed rails when in bed and a tilted chair whenever the resident was sitting, in order to manage a risk for falling. At the time of this inspection staff in the home were unable to provide

documentation to confirm that alternatives to the use of these devices were considered prior to their application.
b) Resident #007 was restrained by the use of a tilted chair whenever sitting and the use of bed rails when in bed, in order to manage a risk of falling. At the time of this inspection staff in the home were unable to provide documentation that identified that alternatives to the use of these devices were considered prior to their application.
c) Resident #014 was restrained by the use of a tilted chair in order to manage a risk of falling. At the time of this inspection staff in the home were unable to provide documentation that identified that alternatives to the use of a tilted chair were considered prior to the application of the devise.

3. Resident #007 and #014 were noted to be restrained by the use of physical devices and there was no documentation in the clinical record to confirm that consent for the use of restraining devices was obtained prior to the use of restraining devices.
a) Resident #007 was being restrained by use of a titled wheelchair whenever sitting and two bed rails whenever in bed, in order to manage a risk of falling. At the time of this inspection staff and clinical documentation confirmed that the home did not have consent to apply these devices.
b) Resident #014 was being restrained by use of a tilted chair and two bed rails whenever in bed, in order to manage a risk of falling. At the time of this inspection staff and clinical documentation confirmed that the home did not have consent to apply these devices.

4. Resident # 005, #007 and #014 were noted to be restrained by the use of physical devices and there was no documentation in the clinical record that identified the person who applied restraining devices and the time the devices were applied.
a) Resident #005 was restrained by use of two bed rails when in bed and a tilted chair whenever the resident was sitting, in order to manage a risk for falling. Staff and clinical documentation confirmed that the person applying these devices and the time the devices were applied is not included in the resident clinical documentation. The DOC confirmed that the documentation format being used at the time of this inspection did not facilitate staff documenting this required information.
b) Resident #007 was restrained by the use of a tilted chair whenever sitting and the use of bed rails when in bed, in order to manage a risk of falling. Staff and clinical documentation confirmed that the person applying these devices and the

time the devices were applied is not included in the resident clinical documentation. The DOC confirmed that the documentation format being at the time of this inspection did not facilitate staff documenting this required information.
c) Resident #014 was restrained by the use of a tilted chair in order to manage a risk of falling. Staff and clinical documentation confirmed that the person applying these devices and the time the devices were applied is not included in the resident clinical documentation. The DOC confirmed that the documentation format being used at the time of this inspection did not facilitate staff documenting this required information.

5. Resident # 005, #007 and #014 were noted to be restrained by the use of physical devices and there was no documentation in the clinical record that identified the resident's response to the restraining devices in place.
a) Resident #005 was restrained by use of two bed rails when in bed and a tilted chair whenever the resident was sitting, in order to manage a risk for falling. Staff and clinical documentation confirmed that the resident's response to being restrained was not documented in the clinical record. The DOC confirmed that the documentation format being used in the home does not facilitate staff documenting this required information.
b) Resident #007 was restrained by the use of a tilted chair whenever sitting and the use of bed rails when in bed, in order to manage a risk of falling. Staff and clinical documentation confirmed that the resident's response to being restrained was not documented in the clinical record. The DOC confirmed that the documentation format being used in the home does not facilitate staff documenting this required information.
c) Resident #014 was restrained by the use of a tilted chair in order to manage a risk of falling. Staff and clinical documentation confirmed that the resident's response to being restrained was not documented in the clinical record. The DOC confirmed that the documentation format being used in the home does not facilitate staff documenting this required information.

6. Resident #005, #007 and #014 were noted to be restrained by the use of physical devices and there was no documentation in the clinical record that identified every release of the restraining devices and all repositioning of the resident for resident #005, resident#007 and resident #014, in relation to the following: [110(7)7]
a) Resident #005 was noted to be restrained by use of a tilted chair and bed rails. There was no documentation in the clinical record related to the application

of the tilted chair or the repositioning of the resident while in the tilted chair. Documentation in the computerized record did not consistently identify when the bed rails were applied or removed when the resident was identified as being in bed.
b) Resident #007 was noted to be sitting in a tilted chair and bed rails. Documentation in the clinical record did not identify every release or when the resident was repositioned when these restraining devices were in use.
3. Resident # 014 was noted to be sitting in a tilted chair and bed side rails. Documentation in the clinical record used by PSW's did not identify every release or when the resident was repositioned when these restraining devices were in use. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 13, 2015

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure the resident's are reassessed and the plan of care reviewed and revised at least every six months, when the resident's care needs change or the care set out in the plan of care has not been effective.
The plan is to include, but is not limited to:
1. The development and implementation of a process where staff identify the expected goals of care related to each established care requirement of the resident and develop a subsequent schedule of determining if those goals have been effective based on the risks to the resident.
2.The ~~Development~~ Development and implementation of a process where staff identify and communicate when resident care needs change and when this is identified what tools staff are to use to reassess the resident and revise the plan of care.
3. The development and implementation of a training program for staff who provide direct care to residents in relation to item 1 and 2 above.
4. The development and implementation of a process for monitoring staff's performance to ensure that all resident's identified care needs are reassess and the plans of care reviewed and revised at regularly scheduled intervals, that staff identify goals of care for each care area and establish subsequent schedules of reassessment based on the risk to the resident, that staff identify when the care needs of residents change and perform the appropriate reassessments.

Error Feb 27/15 1:18pm PHB

The plan is to be submitted to Phyllis Hiltz-Bontje, by e-mail at Phyllis.Hiltzbontje@Ontario.ca on or before March 16, 2015.

Grounds / Motifs :

1. Six residents reviewed were not reassessed and their plans of care reviewed and revised in accordance with the requirements.

2. Resident #005 and resident #007 were not reassessed and their plans of care were not reviewed and revised, in relation to the use of physical restraints for a period of time in excess of six months. [6(10)]
a) Resident #005 was not reassessed in relation to the use of physical restraints for a period of time in excess of six months. The resident's plan of care indicated that the resident was being restrained with the use of a tilted chair when the resident is sitting and the use of two bed rails whenever the resident is in bed and clinical documentation indicated that these interventions to manage a risk for falling where implemented on June 2, 2011 and August 30, 2011 respectively. Minimum Data Set (MDS) reviews completed on November 8, 2013, February 8, 2014 and May 9, 2014 indicated that the use of restraints for

this resident was not triggered and a reassessment of the use of these restraining devices was not completed over this seven month period. A review of the computerized and paper copy of the resident's record indicated that there were no restraint assessment for this period of time.
b) Resident #007 was not reassessed in relation to the use of physical restraints for a period of time in excess of six months. The resident's plan of care indicated that the resident was being restrained by use of a bed rail when in bed and a tilted chair when sitting as interventions to manage a high risk of falling due to failure of the resident to recognize limitations, climbing out of bed and falling from the chair. Clinical documentation indicated that these interventions where implemented on May 23, 2012 and June 16, 2010 respectively. MDS reviews completed on September 1, 2013, December 1, 2013, March 14, 2014 and June 1, 2014 indicated the use of restraints for this resident was not triggered and a reassessment of the use of these restraining devices was not completed over this 10 month period of time. A review of the resident's record indicated that there were no restraint assessment for this period of time.

3. Residents #010, #009 and #005 were not reassessed and their plans of care reviewed and revised in relation to continence care, when it was identified that their care needs had changed. [6(10)(b)]
a) Resident #010 was observed on July 24, July 31 and August 5, 2014. Inspector noted that resident smelled of urine. The resident's MDS for continence, completed on October 1, 2013, indicated that the resident experienced urinary continence deterioration. A review of assessment and plan of care records confirmed that staff had not completed a urinary continence assessment for the resident on admission in December 2012, after urinary continence deterioration in October, 2013 or at any other time, including when care provided was no longer effective. The resident's continence plan of care had not been revised since its creation on January 30, 2013. The Assistant Director of Care (ADOC) confirmed that the resident was not reassessed when their care needs changed, or at any other time, for 18 months. The ADOC further confirmed that the resident's plan of care had not been revised to reflect a change in condition, or at any other time, for 18 months.
b) Clinical records for Resident #009 were reviewed. The resident's Minimum Data Set (MDS) for continence, completed on August 1, 2013, indicated that the resident experienced urinary continence deterioration. A review of assessment and plan of care records confirmed that staff did not complete a urinary continence assessment or revise the resident's continence plan of care since January 27, 2012. The Assistant Director of Care (ADOC) confirmed that the

resident was not reassessed when their care needs changed, or at any other time, for 30 months. The ADOC further confirmed that the resident's plan of care had not been revised to reflect a change in condition, or at any other time, for 30 months.
c) Resident #005 was observed on July 24 and Aug 5, 2014. Inspector noted that resident smelled of urine. A review of assessment and plan of care records confirmed that staff did not complete a urinary continence assessment or revise the resident's continence plan of care since January 25, 2012. Staff interviews indicated that the resident was often resistive to care, making it difficult for staff to provide continence care as specified on the resident's plan of care. The Assistant Director of Care (ADOC) confirmed that the resident was not reassessed for urinary incontinence for 30 months. The ADOC further confirmed that the resident's plan of care had not been revised for 30 months. (584)

4. Resident #002 was not reassessed and the plan of care revised, in relation to nutritional care, when the care set out in the plan had not been effective. [6(10)(c)]
a) The clinical record for Resident #002 was reviewed. It was noted that the resident experienced ongoing constipation and consumed diuretics, placing the resident at heightened dehydration risk. A hydration intervention was created by the Registered Dietitian (RD) of the home on June 4, 2013 instructing staff to provide 60 millilitres of water at noon and evening medication pass. Information collected on admission to the home indicated that this intervention may not be appropriate for this resident. Staff indicated that this intervention would not be appropriate for this resident based on their needs. The RD confirmed that the resident was not receptive to the intervention created a year ago and the plan of care was not updated to reflect this. (584) (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 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 25th day of February, 2015

Signature of Inspector / Signature de l'inspecteur : Phyllis Hiltz-Bontje

Name of Inspector / Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

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