Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l’inspection	Log # / Registre no	Type of Inspection / Genre d’inspection
Jun 14, 2017	2017_616542_0005	001706-17	Resident Quality Inspection

Licensee/Titulaire de permis

LAKELAND LONG TERM CARE SERVICES CORPORATION
6 ALBERT STREET PARRY SOUND ON P2A 3A4

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

LAKELAND LONG TERM CARE SERVICES CORPORATION
6 ALBERT STREET PARRY SOUND ON P2A 3A4

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

JENNIFER LAURICELLA (542), RYAN GOODMURPHY (638), SYLVIE BYRNES (627)

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): February 13-17 and 21-24, 2017.

The following intakes were completed during this inspection:

Follow Up Intake for Compliance Order (CO) #001 from inspection # 2016_264609_0012, related to plan of care was completed during this inspection;

Two complaints submitted to the Director related to concerns with the provisions of care, medication, falls and staff to resident abuse;

Four critical incident reports submitted to the Director related to resident falls resulting in a significant change in resident health status;

Four critical incident reports submitted to the Director related to staff to resident abuse and neglect;

One critical incident report, submitted by the home related to resident to resident abuse.

This inspection addresses both the Lakeland Long Term Care Services Corporation (LTCH #2958) and the Lakeland Long Term Care (Eldcap #2966).

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Practical Nurses (RPNs), Behavioural Clinical Lead, Behavioural Restorative Team (BRT), Personal Support Workers (PSWs), residents and family members.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, employee files and reviewed various licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

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

Inspector #627 completed a review of resident #009's health care record, it was noted on the Treatment Administration Record (TAR) that the resident had altered skin integrity.

A review of the physician's order documents by Inspector #627 and the ADOC revealed a medical order for the area of altered skin integrity that consisted of a specific treatment to be completed daily for one week. After the one week, the physician's order included a different treatment to be completed twice a week.

A review by the Inspector of the Treatment Administration Record (TAR) over a one month period, revealed that the home continued to apply the treatment order for the area of altered skin integrity on a daily basis as opposed to changing it to twice a week as

ordered by the physician.

During an interview with the Inspector, RPN #116 stated that resident #001 had a daily dressing change for the area of altered skin integrity.

During an interview with the Inspector, resident #001 stated that the area of altered skin integrity was completed once a day, usually in the afternoon.

During an interview with the Inspector, the ADOC stated that the order had been transcribed incorrectly. Daily dressing to the area of altered skin integrity should have occurred daily for a week, then it was to be changed after the initial week to twice a week according to the medical order. [s. 6. (4) (b)]

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

A) A complaint was submitted to the Director by resident #003's family member and a Critical Incident (CI) Report, was submitted to the Director by the licensee, both alleging neglect of resident #003.

Inspector #627 completed a review of the complaint which indicated that resident #003's family were concerned that the resident was not being bathed twice weekly.

A review by the Inspector of the "Observation/Flow Sheet Monitoring Form" and progress notes for "Observation/Flow Sheet Monitoring Form" over a two month period, for resident #003 revealed that the resident received a total of five baths. Two refusals were documented for each month; the other missed baths had no documentation regarding the reason why the bath had not been provided.

A review of the care plan in effect during the two month period, indicated the following for the focus of bathing, personal hygiene and pain:

Resident #003 will continue to be bathed twice weekly by staff.
Resident #003’s POA to be contacted if resident #003 refused personal care.

During an interview with the Inspector, PSW #111 stated that if a resident declined to have a bath, or were not bathed due to responsive behaviours, they would try to bathe the resident on the following shift or the next day. PSW #111 confirmed that the missed

baths for resident #003 were not completed on the next shift or the following day. They further stated that the family were made aware when they came in to visit the resident.

During an interview with the Inspector, RPN #112 stated that when a resident refused a bath, the registered staff were notified. Resident #003 often refused their baths. Staff were to reattempt at a later time and if this was unsuccessful, the RPN attempted to convince the resident to bathe as this was often successful. RPN #112 could not tell the Inspector the reasons why so many baths were missed during the specific two month period. As well, when resident #003 refused personal care, the SDM was to be notified. The RPN verified that the family was only notified on one occasion during the two month period of the bath refusal and was not notified of the other refusals.

During an interview with the Inspector, the ADOC stated that resident #003 had missed baths during the two month period, whereby they had not received their baths twice per week due to refusals or responsive behaviours.

B) On February 23, 2017, at approximately 0900 hours (hrs), Inspector #542 noted a strong urine odor around resident #010's room. Inspector #542 entered the resident's room and observed resident #010 sitting in their incontinent product and a t-shirt. It was also observed that their bed and bed linens were saturated with urine. Inspector #627 came to the unit and also observed resident #010 to have a saturated incontinent product. Inspector #627 asked the resident if they had breakfast, the resident replied no, but indicated that they were hungry. Inspector #542 asked RPN #105 if resident #010 had received breakfast. The RPN stated that they had not but would receive something later.

Inspector #542 and #627 observed resident #010 until approximately 0955 am. The resident was not provided with assistance from staff for any of their Activity of Daily Living tasks nor was the resident observed by staff at this time. The resident was not offered breakfast but provided a muffin at approximately 1040 hrs.

Inspector #542 reviewed resident #010's current care plan, specifically under the “Eating” problem statement. It was documented that resident #010 was to be provided with a hot meal via tray service when they refused to go to the dining room for meals. The care plan also identified that resident #010 was to receive a nutritional supplement three times a day at 0800, 1200 and 1700 hours and required extensive assistance with personal care after each incontinent episode.

Inspector #627 reviewed the Medication Administration Record (MAR) and noted that the resident was to receive the nutritional supplement at 0800 hrs and again at 1200 hrs. At approximately 1115 hrs, Inspector #627 interviewed RPN #105 regarding resident #010's nutritional risk. RPN #105 indicated that the resident was not a nutritional risk and that their intake was good. The RPN indicated that resident #010 received a nutritional supplement three times per day and that the PSW staff were to provide the supplement to the resident. RPN #105 indicated that they would be providing resident #010 with their 0800 nourishment now, at 1115 am.

C) During the inspection, resident #011 was identified during stage one as having concerns related to oral hygiene needs not being met. A family member voiced concerns related to care lacking with the resident's oral hygiene needs.

During a review of resident #011's care plan, Inspector #638 identified that the resident had a "mouth care standard in effect" and required oral hygiene care after each meal using a toothbrush. The care plan further indicated that staff were also directed to rinse the resident's mouth and check for deterioration in the resident's oral cavity.

Inspector #638 observed resident #011 on February 22, 2017, during their lunch service on a specific home area. The Inspector observed resident #011 finish their meal and then they were removed from the dining room and placed in the activity room to watch television. No oral hygiene was observed. On February 23, 2017, during the breakfast dining service the Inspector observed resident #011 finish their meal and then was transferred back to bed. The Inspector noted that there was some food debris in the resident's mouth. Furthermore, the Inspector observed resident #011 again during their lunch dining service on the same day. When the resident finished their meal they were brought to the activity room. No oral hygiene was performed.

During an interview with Inspector #638, PSW #124 stated that resident #011 received oral hygiene in the morning and at night and if required. The Inspector reviewed the resident's care plan with PSW #124 who then stated that their oral hygiene was not provided as per the plan of care. PSW #124 then stated that staff should provide care indicated on the plan of care.

Inspector #638 reviewed the quarterly MDS assessment completed in November, 2016, which indicated that resident #011 was a medium risk for dental care.

During an interview with Inspector #638, the Administrator stated that the staff should be

providing care as per the resident’s plan of care. The Administrator then stated that for resident #011 staff should have been providing oral hygiene care as prescribed within the resident’s plan.

D) A Critical Incident (CI) report was submitted to the Director related to an incident where resident #011 had a fall when ambulating and sustained multiple injuries requiring them to be transferred to the hospital.

Inspector #638 reviewed the care plan for resident #011 which indicated that the resident’s interventions for falls included but not limited to ensuring that the resident’s foot rests were on their wheelchair with the brakes engaged while in the dining room.

The Inspector observed resident #011 on February 23, 2017, at 1745 hrs in the dining room with no foot rests on their wheelchair as well as only one brake applied. Inspector #638 then observed resident #011 attempt to stand from their wheelchair. This caused the chair to pivot away from the resident and they almost fell as a result.

During an interview with Inspector #638, PSW #123 listed interventions for resident #011, but stated that the foot rests have not been consistently used for the resident while they were up in their wheelchair for a minimum of one month. PSW #123 stated that staff were required to follow the plan of care and provide care as laid out within the plan, however, it was not always referred to.

The Inspector interviewed RPN #103 who stated that the home completed care plans for all residents, however, staff would not refer to care plans as it required too much time and staff would know the care they should provide to the resident.

During an interview with Inspector #638, RPN #105 stated that the resident’s foot rests had not been used for a while since the table would not accommodate that intervention. The RPN stated that the home did not trial different seating options in an attempt to accommodate the foot rests and staff disregarded the intervention in the plan of care. RPN #105 then stated that they should have implemented the care according to the care plan as per the home’s policy.

During an interview with Inspector #638, the Administrator stated that staff should have provided care as per the resident’s plan of care.

E) A Critical Incident (CI) Report was submitted to the Director, for staff to resident

emotional abuse. It was documented on the CI report that RPN #128 had forced resident #020 to bathe a certain way even though their care plan indicated differently. PSW #120 and PSW #123 had witnessed resident #020 with RPN #128 on that specific day, the resident repeatedly asked RPN #128 to stop, causing the resident to become distressed. RPN #128 also failed to provide resident #020 with their as needed (PRN) medication prior to the bathing activity as per the plan of care.

Inspector #542 reviewed resident #020’s care plan at the time of the incident and the Medication Administration Record (MAR). The care plan indicated that resident #020 was to receive PRN medication for care and prior to their bathing activity. A care plan intervention was updated to include that staff were to bathe the resident a particular way to elicit comfort and decrease agitation. The MAR record was reviewed and there was no documentation to indicate that resident #020 had an order for the specific PRN medication. There was an order for a different medication to be administered one hour prior to bathing and half a tablet twice a day as needed for care. There was no documentation to indicate that it was provided to the resident on the day that the emotional abuse occurred.

On February 22, 2017, Inspector #542 spoke with PSW #123, who was present during part of resident #020's bathing routine. PSW #123 stated that they felt that RPN #128 was too stern and should have stopped as the resident was too agitated. They also indicated that the resident would often refuse bathing a particular way and were to be bathed a different way.

On February 23, 2017, Inspector #542 met with the Director of Care (DOC). The DOC indicated that RPN #128 failed to follow resident #020’s plan of care. [s. 6. (7)]

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

A) On February 15, 2017, Inspector #638 observed resident #011 to not have a functioning resident-staff communication and response system in their room. Inspector #638 observed resident #011’s room, and was unable to activate the bedside call bell in the resident’s room.

Inspector #638 reviewed the care plan of resident #011 which identified that, for a specific reason staff have removed resident #011’s call bell and electrical wires.

Observations made by Inspector #638 on February 15 and 17, 2017, indicated that resident #011 had a call bell in their room and at their bedside within reach, however it was not functioning.

During an interview with Inspector #638, PSW #102 stated that resident #011's care plan did not give a true representation of the resident's current needs.

Inspector #638 conducted a review of resident #011's care plan with RPN #103 who stated that the care plan did not give a true representation of the resident's current needs and should have been updated accordingly as theirs needs change.

During an interview with Inspector #638, the ADOC stated that the home should update the care plan whenever there is a change in a resident's status, their care needs change or care interventions have been ineffective.

B) On February 14, 2017, Inspector #542 observed resident #010's room and was unable to identify a resident-staff communication system in their room.

Inspector #638 reviewed resident #010's care plan, which indicated under the focus heading "Agitated Behaviour" that staff were aware that the resident did not have a call bell. The care plan further indicated that when staff replaced the call bell it would cause resident #010 to become agitated. The Inspector further identified under the focus heading "Falls/Balance" that staff were to remind resident #010 to call for assistance and place the call bell within their reach.

During an interview with Inspector #638, PSW #119 stated that the call bell should be identified within the resident's care plan. The Inspector reviewed resident #010's care plan with PSW #119 who stated that the call bell interventions were not current with what the resident required.

The Inspector conducted an interview with RPN #105 who stated that resident #010's call bell had been removed from their room for a specific reason. RPN #105 also indicated that resident #010 was being monitored on an hourly basis and a "stop and go" intervention was implemented.

During an interview with Inspector #638, the ADOC stated that the care plan should have provided a clear representation of the resident's needs. The ADOC then stated that the

care plan should have been updated in its entirety in order to demonstrate a true picture of the resident’s needs.

The home’s policy titled “Care Plan” RSL-DOC-045 last revised March 2016, indicated that registered nursing staff and other members of the home were to update the resident's plan whenever the resident’s care needs changed.

C) On February 23, 2017, at approximately 0900 hours (hrs), Inspector #542 noted a strong urine odor around resident #010's room. Inspector #542 entered the resident's room and observed resident #010 sitting in their incontinent product and a t-shirt. It was also observed that their bed and bed linens were saturated with urine. Inspector #627 came to the unit and also observed resident #010 to have a saturated incontinent product.

Resident #010’s current plan of care indicated that staff were to be reminded that resident #010 may become more frequently soiled daily as a result of responsive behaviours.

A review of the most current Urinary Continence Assessment, indicated that resident #010 was frequently incontinent of urine and that the toileting plan was effective.

On February 24, 2017, Inspector #542 spoke with the Behavioural Clinical Lead. They indicated that the Behaviour Restorative Team (BRT) had noticed that resident #010’s room had a strong urine odor and that their care needs had increased for the past month however the resident had not been reassessed.

D) On February 23, 2017, at 1000 hours, Inspector #627 observed resident #002 lying in bed. Their bed was noted to be in a raised position.

A review of the care plan in effect at the time of the observation indicated under the focus of falls that the bed was to be in the lowest position when the resident was sleeping and that the resident was not strong enough to stand and slid to the floor.

During an interview with RPN #115, they stated that resident #002’s bed was no longer left in the lowest position as this was a risk for them as they were now able to get up independently. They further stated that the bed was to be left in “the lowest safest position”, which for this resident was in the raised position as the resident got up independently and having the bed at the lowest position made getting up unsafe for

resident #002. They stated that the care plan had not been revised.

During an interview with the Inspector, the ADOC stated that the care plan should have been revised to indicate that the bed was to be at the "lowest safest position" which may be partially raised, to facilitate safe self-transfers. [s. 6. (10) (b)]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan of care had not been effective.

On February 23, 2017, resident #010 was observed in their room at approximately 0900. They were incontinent of urine and their incontinent product was saturated with urine. Their bedding was also observed to be soiled with urine. The resident was not provided with am care until approximately 1040 am.

Inspector #542 reviewed resident #010's current care plan. Under the problem statement, "Personal Hygiene" it was documented that the Behaviour Restorative Team (BRT) had initiated a routine to assist staff with being able to provide care to resident #010. The routine with BRT was initiated during a specific month in 2016.

On February 24, 2017, Inspector #542 spoke with Behaviour Restorative Team (BRT) #126. They indicated that they had developed a plan in an attempt to have resident #010 accept care in the am. They implemented the plan and tried it for one week. BRT #126 stated that the plan was not effective and they were recently going to start a new plan however the home ended up in an outbreak. Despite the fact that the resident's needs had changed the care plan had not been updated or revised for numerous months. BRT #126 stated that resident #010 needed to be assessed often, staff had to gauge resident #010's mood and that plans do not work for them.

On February 24, 2017, Inspector #542 interviewed the Behavioural Clinical Coordinator. They indicated that their team had observed that resident #010's care needs had changed over the last month and that they required more assistance with care. They also indicated that no referrals were completed recently for resident #010 however the BRT staff was going to institute new interventions/routine for resident #010 prior to the outbreak but this did not occur. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001, 002 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 to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident to staff communication and response system was easily seen, accessed and used by residents, staff and visitors at all times.

A) As a result of a stage one trigger, resident #012 was observed with no call bell in their room.

Observations made February 16, 2017, at 0900 hours indicated that resident #012 had no call bell connected to the port in the resident's room. PSW #107 stated that the resident required a call bell and that the resident was able to use their call bell to request assistance.

Inspector #638 reviewed resident #012's care plan which indicated under the focus "Falls/Balance" that staff were to place the resident's call bell within reach. Inspector #638 made observations on February 21, 2017, at 1045 which indicated that resident #012's call bell was not in the resident's room.

During an interview with Inspector #638, PSW #106 stated that resident #012 required a call bell in their room as per the home's policy. PSW #106 stated that resident #012 did not have access to their bed side call bell as it was not plugged into the call system.

B) On February 23, 2017, at 0900 hours, Inspector #627 entered resident #002's room and found the resident lying on their back, with their feet on the ground as if attempting to get up. The Inspector attempted to reach the call bell to call for assistance, however the call bell was twisted behind the bed, out of reach of the resident and staff members. The Inspector called for assistance using the pad on the wall.

During an interview with the Inspector, RPN #115 stated that the resident no longer used a call bell.

A review of the care plan in effect at the time of the inspection listed under seven separate focus statements that the call bell was to be within reach.

During an interview with the ADOC they confirmed that a call bell should be accessible to resident #002 and to staff members who provided care to the resident. [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 to ensure that the resident to staff communication and response system was easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #010 was protected from abuse by anyone and shall ensure that residents were not neglected by the licensee or staff.

O. Reg. 79/10, s. 5 defines neglect as, the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

During the inspection, Inspector #542 and #627 made on observations on February 14 and 15, 2017. It was noted by the Inspectors that a strong urine odor was present in a specific home area, particularly by resident #010’s room. Inspector #542 also noted on February 14, 2017, that resident #010 did not have a call bell attached to the wall in their room. A PSW informed this Inspector that they did not have a call bell due to a particular reason and that it was on their care plan.

On February 23, 2017, at approximately 0900, Inspector #542 noted a strong urine odor around resident #010’s room. In an interview with RPN #105, Inspector #542 asked where the strong odor of urine was coming from. RPN #105 pointed to resident #010’s

room and indicated that they typically keep their room door shut, to prevent the urine odor from lingering into the hallway. The RPN then proceeded to close resident #010’s door. Inspector #542 entered the resident’s room and observed resident #010 sitting in their incontinent product and a t-shirt. It was also observed that their bed and bed linens were saturated with urine. Inspector #627 came to the unit and also observed resident #010 to have a saturated incontinent product. Inspector #627 asked the resident if they had breakfast, the resident replied no and indicated that they were hungry. Inspector #542 asked RPN #105 if resident #010 had received breakfast. The RPN stated that they had not but would receive something later.

Inspector #542 and #627 observed resident #010 until approximately 0955 am. The resident was not provided with assistance from staff for any of their Activity of Daily Living tasks nor was the resident observed by staff at this time. The resident was not offered breakfast.

Inspector #542 proceeded to inform the ADOC at approximately 1000 am, the ADOC instructed staff to get the resident up and dressed.

The licensee submitted a Critical Incident (CI) report to the Director for improper/incompetent treatment of a resident #010 that resulted in harm or risk to a resident. The CI report was submitted to the Director after the licensee was made aware of the resident’s status by Inspector #542 and #627.

The ADOC informed Inspector #542 that the resident was allowed to sleep in and that this was well care planned. They also stated that PSW #122 observed resident #010 at 0730 and they were still sleeping and then the staff became busy.

Inspector #542 reviewed the current care plan and the following was documented under the heading, "Sleep and Rest, in the morning when staff approach resident #010 and they do not wish to get up, staff to make an agreement with them to come back in thirty minutes."

On March 13, 2017, Inspector #542 spoke with resident #010's family member. They indicated that the home had contacted them after the incident to inform them that resident #010's was forgotten about in the morning. They also stated that they would like the home to ensure that resident #010 is bathed and provided with meals however understand that they can be difficult at times.

Additionally, the home failed to protect resident #010 from abuse and neglect as evidenced by non-compliance identified during this inspection related to:

- WN #1, LTCHA, 2007, s. 6 (7) where the home failed to ensure that resident #010 was provided with the care set out as specified in their plan of care related to incontinence care and nutritional supplements;
- WN #1, LTCHA, 2007, s. 6 (10) (b) where the home failed to ensure that resident #010 was reassessed and that their plan of care was revised when resident #010's care needs changed in relation to the resident-staff communication response system and skin and wound care interventions;
- WN #1, LTCHA, 2007, s. 6 (10) (c) where the home failed to ensure that resident #010 was reassessed and the plan of care reviewed and revised when the care set out in the plan was not effective, specifically related to their responsive behaviours. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents were protected from abuse by anyone and shall ensure that residents were not neglected by the licensee or staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A) A Critical Incident (CI) Report was submitted to the Director alleging that improper/incompetent treatment of a resident that resulted in harm or risk to a resident had occurred. It was also indicated that six different residents were not provided with proper care, ranging from, inadequate peri-care and being left in soiled incontinent products.

Inspector #542 reviewed the home's investigation file which concluded that PSW #120 and PSW #127 worked on the day when the alleged care was not provided adequately to the six named residents in the CI report. Through the home's investigation it was determined that both PSW staff members had not reviewed any of the residents care plan's prior to providing care. They agreed that they were overwhelmed on that shift as they were working short and failed to communicate to the RPN working that day. PSW #120 and PSW #127 received counsel and discipline from the ADOC.

The Inspector reviewed PSW #120 and PSW #127's employee files. Inspector #542 noted that PSW #127 had another investigation document in their file indicating disciplinary action related to a similar incident. Inspector reviewed PSW #120's employee file and noted that no other discipline or coaching incidents were part of their file.

On February 22, 2017, Inspector #542 met with the Assistant Director of Care (ADOC). They indicated that they met with both of the PSW's that worked the day when the alleged neglect occurred. The PSW's informed them that they felt rushed and that they did not follow each of their assignments nor did either PSW review the residents' plan of care. Both PSW's were provided with disciplinary action.

On February 22, 2017, Inspector #542 spoke with PSW #121. PSW #121 acknowledged that they reported the neglect as they came on shift after the day shift and witnessed some of the residents that were not provided with proper care. PSW #121 stated that they reported to RPN #105 and physically showed them the resident's that were saturated with urine or dried feces.

On February 23, 2017, Inspector #542 interviewed RPN #105. Inspector #542 asked RPN #105 if they witnessed that the care had not been completed properly on some of the resident's that day. RPN #105 indicated that the two PSW's working with them on the following shift came and got them so that they could see the lack of care that was provided during the day shift. RPN #105 specifically remembers resident #022's incontinent product completely soiled with dried urine and feces on it. Resident #029

was also saturated with urine and their water proof wound dressing had slid right off. Resident #024 had a dry incontinent product however they had a large amount of dried feces on their peri-area. RPN #105 indicated that they reported the lack of care to the ADOC via email on the same day that the CI report was submitted to the Director.

On February 23, 2017, Inspector #542 interviewed RPN #113. RPN #113 was working on the same shift when that the alleged improper care occurred, they were an extra RPN to assist on the unit and other units that were working without a full complement of staff. RPN #113 wasn't aware that the PSW's were having a difficult time completing the care for the resident's that day shift, however they did notice that PSW #120 and PSW #127 were not as engaged in the afternoon towards the end of their shift..

On February 24, 2017, Inspector #542 spoke to PSW #127. PSW #127 was one of the PSW staff that were working on the day shift that the alleged neglect of resident occurred. Inspector #542 asked PSW #127 to explain what occurred that day. PSW #127 acknowledged that they had a very busy day and that they were short one PSW. They also indicated they were not familiar with the unit. PSW #127 stated that they did the best that they could and acknowledged that they should have reviewed the resident care plans prior to providing care to the residents.

B) A Critical Incident (CI) Report was submitted to the Director, for staff to resident emotional abuse. It was documented on the CI report that the alleged incident occurred nineteen days prior to the submission of the CI report. The CI report indicated that RPN #128 had forced resident #020 to bathe a certain way even though their care plan indicated differently. PSW #120 and PSW #123 had witnessed resident #020 with RPN #128 on that specific day, the resident repeatedly asked RPN #128 to stop, causing the resident to become distressed. RPN #128 also failed to provide resident #020 with their as needed (PRN) medication prior to the bathing activity as per the plan of care. The CI report was amended to include that it was determined that emotional abuse of resident #020 did occur and that RPN #128 resigned from their position. PSW #123 received disciplinary action for failure to report the incident immediately.

On February 22, 2017, Inspector #542 spoke with PSW #123, who was present during part of the bathing activity of resident #020. PSW #123 stated that they felt that RPN #128 was too stern and should have stopped the bathing activity as the resident was too agitated. PSW #123 reported the alleged abuse fifteen days after the incident of abuse occurred and received disciplinary action.

On February 23, 2017, Inspector #542 met with the Director of Care (DOC). The DOC stated that the PSW staff were reluctant to report the RPN because they were a registered staff member. Both PSW's were made aware that they reported the incident too late and it should have been immediate. The DOC felt that RPN #128 was abusive towards resident #020.

On February 24, 2017, Inspector #542 met with PSW #120 who was present during the time that resident #020 was receiving their bathing activity. PSW #120 informed this Inspector that RPN #128 had told resident #020 that they were dirty and required to be bathed. PSW #120 also stated that resident #020 was visibly upset as they were crying, agitated and started to kick the RPN.

Inspector #542 reviewed the home's policy titled, "Abuse Policy – Definition." The policy identifies that abuse and or neglect will not be tolerated under any circumstance and for any reason. It also defines neglect as; the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being of one or more residents. [s. 20. (1)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee had failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident that resulted in harm or a risk of harm has occurred or may occur, immediately reports the suspicion and the information upon which it was based to the Director.

A Critical Incident (CI) Report was submitted to the Director, for staff to resident emotional abuse. It was documented on the CI report that the alleged incident occurred 19 days prior to the submission of the CI report. The CI report indicated that RPN #128 had forced resident #020 to bathe a certain way even though their care plan indicated differently. PSW #120 and PSW #123 had witnessed resident #020 with RPN #128 on that specific day, the resident repeatedly asked RPN #128 to stop, causing the resident to become distressed. The CI report indicated that the alleged incident occurred on a specific day and it was reported to the Administrator and the Director of Care 15 days later. The licensee submitted the CI report 4 days after the abuse was reported.

On February 23, 2017, Inspector #542 met with the Director of Care (DOC), who acknowledged that the home did not report the incident to the Director until 4 days after becoming aware of it. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident that resulted in harm or a risk of harm has occurred or may occur, immediately reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #6: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident’s admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

A Critical Incident (CI) Report was submitted to the Director, related to an incident of resident to resident abuse where resident #013 struck resident #014 causing them to fall and sustain an injury where they were transferred to the hospital.

A review of resident #013's progress notes indicated that they were transferred to the hospital on the day of the incident, where they received interventions regarding their injury. The progress notes further identified that resident #013 returned from the hospital with two areas of altered skin integrity.

During an interview with Inspector #638, RPN #105 stated that a head to toe skin assessment is completed on any return from the hospital. The RPN then stated that the assessment should be completed the day of return in order to ensure that any new area of altered skin integrity could be identified immediately.

Inspector #638 conducted a review of resident #013's health care records. Upon review the Inspector was unable to locate any head to toe skin assessments completed upon return from the hospital. The next completed skin assessment occurred 7 days after the resident returned to the home.

The home's policy titled "Re-Admission from Hospital" RSP-ADT-015 last revised March 2016, indicated that upon return from hospital, the registered nursing staff would observe the resident for skin abrasions or open areas using the Head to Toe Assessment form on Med e-Care.

During an interview with Inspector #638, the ADOC stated that the head to toe skin assessment should have been completed within the first 24 hours of returning from hospital to ensure that all new areas of altered skin integrity were noted and monitored accordingly. The ADOC reviewed resident #013's health care records and could not identify any completed head to toe skin assessments that were completed within the first 24 hours. The ADOC stated that they would have expected an assessment was completed on the day of return. [s. 50. (2) (a) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents exhibiting altered skin integrity receive a skin assessment by a member of the registered nursing staff upon any return from hospital and that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) On February 23, 2017, RPN #115 and Inspector #627 completed a count of the narcotics kept on a specific unit of the home. During the narcotic count it was noted that the narcotic control sheet indicated that resident #028's blister pack should have contained two tablets of a specific medication in their blister pack, however the blister pack contained three tablets.

The Inspector reviewed the policy titled “Administering and Documenting Controlled Substances Using MED e-care, #9:11", last revised December 2016, which indicated that: the controlled substance was to be administered to the resident, as ordered. The controlled substance medication was to be documented as administered on the electronic medication administration record (eMAR) upon administration and before

administering the next resident's medication (s).

RPN #115 stated that they had forgotten to administer resident #028's medication last night although they had signed the eMAR record that they had administered the medication.

B) During a tour of another home area, Inspector #627 and Inspector #542 observed resident #010 sitting in a lazy boy recliner in their room. Inspector #627 asked the resident if they had breakfast yet to which the resident replied no but they would like to have breakfast.

A review of the resident #010 plan of care indicated that the resident was to receive a nutritional supplement three times daily. The electronic medication administration record (EMARI) indicated the times of administration as 0800, 1200, 1700 hours. During the same review, the Inspector noted from the physician's order and the eMAR records that resident #010 was to receive 2 specific medications daily at 0800 hours and another at 1500 hours.

During an interview with the Inspector, PSW #115 stated that the scheduled 0800 hr nutritional supplement was given at 1115 hours. RPN #105 stated that the PSWs usually passed the supplements however, since they needed to give the resident their 0800 medications, they had brought the supplement and given the resident their 0800 medication at 1115 hours. The RPN further stated that although the medications were ordered for 0800 hours, the resident rarely received them at this time, as they were asleep.

A review of the policy titled "Processing Time Changes and Default Pass Times Using MED e-care", #9.7, last revised March 2012, indicated that; "Routinely dosed oral solid strip medications are dispensed in specific pass times that are home-specific and predetermined, unless otherwise noted by the physician on the Physician's order from.

Policy titled "Administering routine Medications Using Med e-care" #9.10, last revised June 2014, indicated that: the medications are administered to the resident, as ordered.

A review of the home's Schedule of Medication Administration times indicated that medications ordered once a day were to be given at 0800 hours and medications ordered twice daily were to be given at 0800 and 1500 hours.

During an interview with the Inspector, the ADOC stated that if the resident was not receiving the medication ordered at 0800 hours, then the medication administration times should have been changed as this was not reflective of the care given. [s. 131. (2)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee had failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the residents' health.

A complaint was submitted to the Director indicating that resident #004 had received a medication that they were allergic to despite the home being aware of the allergy.

Inspector #542 completed a health care record review for resident #004. The admission documents from the home titled, "Resident Profile and 24 Hour Admission Care Plan" that were completed with resident #004's family indicated that resident #004 had a known allergy to specific medication. The family member informed the Long-Term Care Home that the medication caused resident #004 to feel unwell.

Inspector #542 reviewed the Physician's order document from a specific day and noted that an order was written for this medication three times per day.

A review of the Medication Administration Record over a one month period was completed. It was documented that resident #004 received the medication for 14 days during the month, a total of 37 doses.

A review of resident #004's progress notes revealed that 16 days after the medication was ordered, a discussion was held with a family member which indicated that they were angry that resident #004 was administered the medication that they had an allergy to and felt that their decline in health status was a result of the medication. The medication was discontinued on the day the meeting was held with the family according to the physician's order sheets.

On February 23, 2017, Inspector #542 interviewed the Assistant Director of Care (ADOC). They stated that the home failed to complete a medication incident report and that resident #004 should not have received the medication. [s. 135. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the residents' health, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any policy, protocol, procedure, strategy or system instituted was complied with.

On February 23, 2017, during a narcotic count by RPN #115 and Inspector #627, it was noted that the narcotic record for resident #027's medication indicated six tablets were remaining. A count of the tablets in the blister pack by the Inspector and RPN #115 revealed that five and half a tablets remained; half a tablet was missing.

A review of resident's #027's progress notes, revealed that the medication was administered on a specific day.

A review of the policy titled “Administering and Documenting Controlled Substances Using MED e-care, #9:11, last revised December 2016, indicated that: the controlled substance was to be administered to the Resident, as ordered. The controlled substance medication was to be documented as administered on the electronic medication administration record (eMAR) upon administration and before administering the next resident’s medication (s).

During an interview with the ADOC, it was confirmed that the night shift RPN had administered the medication and had not documented it in the eMar. [s. 8. (1) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had their personal items, including personal aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

Inspector #638 conducted the initial tour of the home on February 13, 2017. During the initial tour, the Inspector observed in the tub room on a specific unit, a set of used and unlabelled comb and nail clippers. The Inspector further identified on another unit, a used and unlabelled razor in the resident tub room as well as a used and unlabelled comb and hair brush in a different unit.

Observations made on another unit on February 14, 2017, indicated that resident #025’s and resident #026’s bathroom each had two used and unlabelled toothbrushes stored together on the resident’s vanity in the residents’ shared bathrooms.

During an interview with Inspector #638, PSW #108, #109 and #110 all stated that it was expected that personal items were labelled and kept with the resident’s belongings. PSW #109 further indicated that staff “just know whose belongings are whose”, however, typical practice is to ensure that all resident personal items are labelled.

During an interview with Inspector #638, the ADOC stated that staff should have ensured that all personal items were labelled so that they would only be used for the resident it was designated for. The ADOC then stated that it was important to ensure that labelling was completed in order to minimize risk to the residents. [s. 37. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when they receive a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint under subsection 101 (1).

A Critical Incident (CI) Report was submitted to the Director alleging that staff were negligent towards resident #003. It was also noted in the CI report that resident #003's family member also submitted an email to the licensee outlining the alleged neglect to the licensee. The complaint letter was not submitted with the CI report.

A complaint letter was submitted to the Director (4 months after the CI was submitted) from resident #003's family member indicating that they were concerned that the licensee did not submit their original complaint to the Director. Resident #003's family member provided a copy of the original letter that was sent to the licensee via email on the day that the home submitted the CI report to the Director.

On November 25, 2016, a review of all compliant letters submitted by Lakeland Long Term Care to the Director failed to identify the complaint email. [s. 103. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of infection prevention and control program.

On February 17, 2017, at 1300 hours, Inspector #627 observed PSW #103 walk out of room a resident's room, which was under droplet and contact isolation. The PSW was noted to be carrying dirty dishes in their right hand. The PSW had removed their mask and their left glove, then proceeded to walk down the hall, into the dining room and dispose of the dishes in a tray located in the dining room. The PSW then walked to the nursing desk, disposed of the glove in the garbage at the nursing desk and performed hand hygiene.

A review by the Inspector of the policy titled "Infection Prevention and Control Manual", policy number: IPC-ADP-035, last revised July, 2013, indicated that "hand hygiene shall be performed after removing PPE including gloves, before leaving the resident's room."

During an interview with the Inspector, PSW #103 stated that this was the only way they knew how to dispose of dirty dishes. They further stated they had been doing this since starting and had not been told this was incorrect.

During an interview with RPN #104, they stated that the dishes which were removed from a resident's room, when they were under isolation were carried to the dining room, cleaned in the sink and stacked. They further stated that they had not noted that this could be a concern for infection control.

During an interview with the Inspector, the Infection Prevention Control Coordinator stated that the expectation for removing dishes from a room under isolation was to bring a tray to the doorway, apply PPE, remove the dishes and place the dirty dishes on the lower tray of a two tiered cart. PPE was then to be removed. The procedure was repeated at the next room. They further stated that removing the dishes from the room and bringing them to the dining room caused a risk of further spreading the infection. [s. 229. (4)]

Issued on this 20th day of June, 2017

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER LAURICELLA (542), RYAN GOODMURPHY (638), SYLVIE BYRNES (627)
Inspection No. / No de l'inspection :	2017_616542_0005
Log No. / Registre no:	001706-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 14, 2017
Licensee / Titulaire de permis :	LAKELAND LONG TERM CARE SERVICES CORPORATION 6 ALBERT STREET, PARRY SOUND, ON, P2A-3A4
LTC Home / Foyer de SLD :	LAKELAND LONG TERM CARE SERVICES CORPORATION 6 ALBERT STREET, PARRY SOUND, ON, P2A-3A4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Steve White

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To LAKELAND LONG TERM CARE SERVICES CORPORATION, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall develop, submit and implement a plan that includes the following:

1. Ensure that resident #010 is provided with proper continence care in order to maintain their level of comfort, is offered three meals a day everyday and provided with any nutritional supplements according to their plan of care.

2. Ensure that resident #011 receives oral hygiene care and prevention of fall interventions as specified in their plan of care.

3. Ensure that all care plans are based on individual resident care needs.

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

The plan shall be submitted, in writing, to Jennifer Lauricella, Long-Term Care Homes Inspector, Long-Term Care Inspections Branch, Ministry of Health and Long-Term Care, Long-Term Care Homes Division,159 Cedar Street, Suite 403, Sudbury ON P3E 6A5, by email at SudburySAO.moh@ontario.ca. Alternatively, the plan may be faxed to the Inspector's attention at (705) 564-3133. This plan must be received by June 30, 2017.

Grounds / Motifs :

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

A) A complaint was submitted to the Director by resident #003's family member and a Critical Incident (CI) Report, was submitted to the Director by the licensee, both alleging neglect of resident #003.

Inspector #627 completed a review of the complaint which indicated that resident #003's family were concerned that the resident was not being bathed twice weekly.

A review by the Inspector of the "Observation/Flow Sheet Monitoring Form" and progress notes for "Observation/Flow Sheet Monitoring Form" over a two month period, for resident #003 revealed that the resident received a total of five baths. Two refusals were documented for each month; the other missed baths had no documentation regarding the reason why the bath had not been provided.

A review of the care plan in effect during the two month period, indicated the following for the focus of bathing, personal hygiene and pain:

Resident #003 will continue to be bathed twice weekly by staff.
Resident #003's POA to be contacted if resident #003 refused personal care.

During an interview with the Inspector, PSW #111 stated that if a resident declined to have a bath, or were not bathed due to responsive behaviours, they would try to bathe the resident on the following shift or the next day. PSW #111 confirmed that the missed baths for resident #003 were not completed on the next shift or the following day. They further stated that the family were made aware when they came in to visit the resident.

During an interview with the Inspector, RPN #112 stated that when a resident refused a bath, the registered staff were notified. Resident #003 often refused their baths. Staff were to reattempt at a later time and if this was unsuccessful, the RPN attempted to convince the resident to bathe as this was often successful. RPN #112 could not tell the Inspector the reasons why so many baths were missed during the specific two month period. As well, when resident #003 refused personal care, the SDM was to be notified. The RPN verified that the family was only notified on one occasion during the two month period of the bath refusal and was not notified of the other refusals.

During an interview with the Inspector, the ADOC stated that resident #003 had missed baths during the two month period, whereby they had not received their

baths twice per week due to refusals or responsive behaviours.

B) On February 23, 2017, at approximately 0900 hours (hrs), Inspector #542 noted a strong urine odor around resident #010's room. Inspector #542 entered the resident's room and observed resident #010 sitting in their incontinent product and a t-shirt. It was also observed that their bed and bed linens were saturated with urine. Inspector #627 came to the unit and also observed resident #010 to have a saturated incontinent product. Inspector #627 asked the resident if they had breakfast, the resident replied no, but indicated that they were hungry. Inspector #542 asked RPN #105 if resident #010 had received breakfast. The RPN stated that they had not but would receive something later.

Inspector #542 and #627 observed resident #010 until approximately 0955 am. The resident was not provided with assistance from staff for any of their Activity of Daily Living tasks nor was the resident observed by staff at this time. The resident was not offered breakfast but provided a muffin at approximately 1040 hrs.

Inspector #542 reviewed resident #010's current care plan, specifically under the "Eating" problem statement. It was documented that resident #010 was to be provided with a hot meal via tray service when they refused to go to the dining room for meals. The care plan also identified that resident #010 was to receive a nutritional supplement three times a day at 0800, 1200 and 1700 hours and required extensive assistance with personal care after each incontinent episode.

Inspector #627 reviewed the Medication Administration Record (MAR) and noted that the resident was to receive the nutritional supplement at 0800 hrs and again at 1200 hrs. At approximately 1115 hrs, Inspector #627 interviewed RPN #105 regarding resident #010's nutritional risk. RPN #105 indicated that the resident was not a nutritional risk and that their intake was good. The RPN indicated that resident #010 received a nutritional supplement three times per day and that the PSW staff were to provide the supplement to the resident. RPN #105 indicated that they would be providing resident #010 with their 0800 nourishment now, at 1115 am.

C) During the inspection, resident #011 was identified during stage one as having concerns related to oral hygiene needs not being met. A family member voiced concerns related to care lacking with the resident's oral hygiene needs.

During a review of resident #011's care plan, Inspector #638 identified that the resident had a "mouth care standard in effect" and required oral hygiene care after each meal using a toothbrush. The care plan further indicated that staff were also directed to rinse the resident's mouth and check for deterioration in the resident's oral cavity.

Inspector #638 observed resident #011 on February 22, 2017, during their lunch service on a specific home area. The Inspector observed resident #011 finish their meal and then they were removed from the dining room and placed in the activity room to watch television. No oral hygiene was observed. On February 23, 2017, during the breakfast dining service the Inspector observed resident #011 finish their meal and then was transferred back to bed. The Inspector noted that there was some food debris in the resident's mouth. Furthermore, the Inspector observed resident #011 again during their lunch dining service on the same day. When the resident finished their meal they were brought to the activity room. No oral hygiene was performed.

During an interview with Inspector #638, PSW #124 stated that resident #011 received oral hygiene in the morning and at night and if required. The Inspector reviewed the resident's care plan with PSW #124 who then stated that their oral hygiene was not provided as per the plan of care. PSW #124 then stated that staff should provide care indicated on the plan of care.

Inspector #638 reviewed the quarterly MDS assessment completed in November, 2016, which indicated that resident #011 was a medium risk for dental care.

During an interview with Inspector #638, the Administrator stated that the staff should be providing care as per the resident's plan of care. The Administrator then stated that for resident #011 staff should have been providing oral hygiene care as prescribed within the resident's plan.

D) A Critical Incident (CI) report was submitted to the Director related to an incident where resident #011 had a fall when ambulating and sustained multiple injuries requiring them to be transferred to the hospital.

Inspector #638 reviewed the care plan for resident #011 which indicated that the resident's interventions for falls included but not limited to ensuring that the

resident's foot rests were on their wheelchair with the brakes engaged while in the dining room.

The Inspector observed resident #011 on February 23, 2017, at 1745 hrs in the dining room with no foot rests on their wheelchair as well as only one brake applied. Inspector #638 then observed resident #011 attempt to stand from their wheelchair. This caused the chair to pivot away from the resident and they almost fell as a result.

During an interview with Inspector #638, PSW #123 listed interventions for resident #011, but stated that the foot rests have not been consistently used for the resident while they were up in their wheelchair for a minimum of one month. PSW #123 stated that staff were required to follow the plan of care and provide care as laid out within the plan, however, it was not always referred to.

The Inspector interviewed RPN #103 who stated that the home completed care plans for all residents, however, staff would not refer to care plans as it required too much time and staff would know the care they should provide to the resident.

During an interview with Inspector #638, RPN #105 stated that the resident's foot rests had not been used for a while since the table would not accommodate that intervention. The RPN stated that the home did not trial different seating options in an attempt to accommodate the foot rests and staff disregarded the intervention in the plan of care. RPN #105 then stated that they should have implemented the care according to the care plan as per the home's policy.

During an interview with Inspector #638, the Administrator stated that staff should have provided care as per the resident's plan of care.

E) A Critical Incident (CI) Report was submitted to the Director, for staff to resident emotional abuse. It was documented on the CI report that RPN #128 had forced resident #020 to bathe a certain way even though their care plan indicated differently. PSW #120 and PSW #123 had witnessed resident #020 with RPN #128 on that specific day, the resident repeatedly asked RPN #128 to stop, causing the resident to become distressed. RPN #128 also failed to provide resident #020 with their as needed (PRN) medication prior to the bathing activity as per the plan of care.

Inspector #542 reviewed resident #020's care plan at the time of the incident

and the Medication Administration Record (MAR). The care plan indicated that resident #020 was to receive PRN medication for care and prior to their bathing activity. A care plan intervention was updated to include that staff were to bathe the resident a particular way to elicit comfort and decrease agitation. The MAR record was reviewed and there was no documentation to indicate that resident #020 had an order for the specific PRN medication. There was an order for a different medication to be administered one hour prior to bathing and half a tablet twice a day as needed for care. There was no documentation to indicate that it was provided to the resident on the day that the emotional abuse occurred.

On February 22, 2017, Inspector #542 spoke with PSW #123, who was present during part of resident #020's bathing routine. PSW #123 stated that they felt that RPN #128 was too stern and should have stopped as the resident was too agitated. They also indicated that the resident would often refuse bathing a particular way and were to be bathed a different way.

On February 23, 2017, Inspector #542 met with the Director of Care (DOC). The DOC indicated that RPN #128 failed to follow resident #020's plan of care. [s. 6. (7)]

The decision to issue a compliance order was based on the severity, which was determined to be minimal harm or potential for actual harm to the health and safety of the residents. The scope was determined to be a pattern of residents affected. And despite ongoing noncompliance within this provision of the legislation the licensee continues with noncompliance.

There was a history of a previous noncompliance identified during the following inspection:

- A voluntary plan of correction (VPC) was issued during Resident Quality Inspection # 2014_332575_0008 served to the home on July 4, 2014. (638)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 14, 2017

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_264609_0012, CO #001;

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 develop, submit and implement a plan that includes the following:

1. An audit process to monitor that resident #010 and #011's care plans remain current as per each resident's care requirements.

2. Ensure that resident #010's care plan is reflective of their current care needs and that the Behaviour Restorative Team is actively involved in the development of resident #010's plan of care in attempt to ensure that resident #010 is receiving proper assistance with all of their Activities of Daily Living.

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

The plan shall be submitted, in writing, to Jennifer Lauricella, Long-Term Care Homes Inspector, Long-Term Care Inspections Branch, Ministry of Health and Long-Term Care, Long-Term Care Homes Division,159 Cedar Street, Suite 403, Sudbury ON P3E 6A5, by email at SudburySAO.moh@ontario.ca. Alternatively, the plan may be faxed to the Inspector's attention at (705) 564-3133. This plan must be received and fully implemented by June 30, 2017.

Grounds / Motifs :

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

A) On February 15, 2017, Inspector #638 observed resident #011 to not have a functioning resident-staff communication and response system in their room. Inspector #638 observed resident #011's room, and was unable to activate the bedside call bell in the resident's room.

Inspector #638 reviewed the care plan of resident #011 which identified that, for a specific reason staff have removed resident #011's call bell and electrical wires.

Observations made by Inspector #638 on February 15 and 17, 2017, indicated that resident #011 had a call bell in their room and at their bedside within reach,

however it was not functioning.

During an interview with Inspector #638, PSW #102 stated that resident #011's care plan did not give a true representation of the resident's current needs.

Inspector #638 conducted a review of resident #011's care plan with RPN #103 who stated that the care plan did not give a true representation of the resident's current needs and should have been updated accordingly as theirs needs change.

During an interview with Inspector #638, the ADOC stated that the home should update the care plan whenever there is a change in a resident's status, their care needs change or care interventions have been ineffective.

B) On February 14, 2017, Inspector #542 observed resident #010's room and was unable to identify a resident-staff communication system in their room.

Inspector #638 reviewed resident #010's care plan, which indicated under the focus heading "Agitated Behaviour" that staff were aware that the resident did not have a call bell. The care plan further indicated that when staff replaced the call bell it would cause resident #010 to become agitated. The Inspector further identified under the focus heading "Falls/Balance" that staff were to remind resident #010 to call for assistance and place the call bell within their reach.

During an interview with Inspector #638, PSW #119 stated that the call bell should be identified within the resident's care plan. The Inspector reviewed resident #010's care plan with PSW #119 who stated that the call bell interventions were not current with what the resident required.

The Inspector conducted an interview with RPN #105 who stated that resident #010's call bell had been removed from their room for a specific reason. RPN #105 also indicated that resident #010 was being monitored on an hourly basis and a "stop and go" intervention was implemented.

During an interview with Inspector #638, the ADOC stated that the care plan should have provided a clear representation of the resident's needs. The ADOC then stated that the care plan should have been updated in its entirety in order to demonstrate a true picture of the resident's needs.

The home's policy titled "Care Plan" RSL-DOC-045 last revised March 2016, indicated that registered nursing staff and other members of the home were to update the resident's plan whenever the resident's care needs changed.

C) On February 23, 2017, at approximately 0900 hours (hrs), Inspector #542 noted a strong urine odor around resident #010's room. Inspector #542 entered the resident's room and observed resident #010 sitting in their incontinent product and a t-shirt. It was also observed that their bed and bed linens were saturated with urine. Inspector #627 came to the unit and also observed resident #010 to have a saturated incontinent product.

Resident #010's current plan of care indicated that staff were to be reminded that resident #010 may become more frequently soiled daily as a result of responsive behaviours.

A review of the most current Urinary Continence Assessment, indicated that resident #010 was frequently incontinent of urine and that the toileting plan was effective.

On February 24, 2017, Inspector #542 spoke with the Behavioural Clinical Lead. They indicated that the Behaviour Restorative Team (BRT) had noticed that resident #010's room had a strong urine odor and that their care needs had increased for the past month however the resident had not been reassessed.

D) On February 23, 2017, at 1000 hours, Inspector #627 observed resident #002 lying in bed. Their bed was noted to be in a raised position.

A review of the care plan in effect at the time of the observation indicated under the focus of falls that the bed was to be in the lowest position when the resident was sleeping and that the resident was not strong enough to stand and slid to the floor.

During an interview with RPN #115, they stated that resident #002's bed was no longer left in the lowest position as this was a risk for them as they were now able to get up independently. They further stated that the bed was to be left in "the lowest safest position", which for this resident was in the raised position as the resident got up independently and having the bed at the lowest position made getting up unsafe for resident #002. They stated that the care plan had not been revised.

During an interview with the Inspector, the ADOC stated that the care plan should have been revised to indicate that the bed was to be at the "lowest safest position" which may be partially raised, to facilitate safe self-transfers.
(542)

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan of care had not been effective.

On February 23, 2017, resident #010 was observed in their room at approximately 0900. They were incontinent of urine and their incontinent product was saturated with urine. Their bedding was also observed to be soiled with urine. The resident was not provided with am care until approximately 1040 am.

Inspector #542 reviewed resident #010's current care plan. Under the problem statement, "Personal Hygiene" it was documented that the Behaviour Restorative Team (BRT) had initiated a routine to assist staff with being able to provide care to resident #010. The routine with BRT was initiated during a specific month in 2016.

On February 24, 2017, Inspector #542 spoke with Behaviour Restorative Team (BRT) #126. They indicated that they had developed a plan in an attempt to have resident #010 accept care in the am. They implemented the plan and tried it for one week. BRT #126 stated that the plan was not effective and they were recently going to start a new plan however the home ended up in an outbreak. Despite the fact that the resident's needs had changed the care plan had not been updated or revised for numerous months. BRT #126 stated that resident #010 needed to be assessed often, staff had to gauge resident #010's mood and that plans do not work for them.

On February 24, 2017, Inspector #542 interviewed the Behavioural Clinical Coordinator. They indicated that their team had observed that resident #010's care needs had changed over the last month and that they required more assistance with care. They also indicated that no referrals were completed recently for resident #010 however the BRT staff was going to institute new interventions/routine for resident #010 prior to the outbreak but this did not occur. [s. 6. (10) (c)]

The decision to issue a compliance order was based on the potential for actual harm to the residents' health and safety. The scope was determined to be a pattern and the home continues to have on-going noncompliance in this provision of the legislation. There was a history of previous noncompliance identified during the following inspection:

- A voluntary plan of correction (VPC) was issued during Resident Quality Inspection #2015_332575_0013. (542)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 14, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 14th day of June, 2017

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Jennifer Lauricella

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