Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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
May 16, 2017	2017_624196_0005	005992-17	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET P.O. BOX3251 THUNDER BAY ON P7B 5G7

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

HOGARTH RIVERVIEW MANOR
300 LILLIE STREET THUNDER BAY ON P7C 4Y7

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

LAUREN TENHUNEN (196), DEBBIE WARPULA (577), JULIE KUORIKOSKI (621), SHEILA CLARK (617)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 21 - 24, March 27 - 31, April 3 and 4, 2017.

The following intakes were inspected concurrently:

Critical Incident System (CIS): three intakes related to resident falls; one intake related to alleged staff to resident abuse/neglect; one intake related to a medication incident.

Complaint: two intakes related to resident care concerns; one intake related to resident's plan of care.

Follow up to Compliance Orders: one intake related to 24 hour admission plan of care; one intake related to resident plans of care; one intake related to resident fall prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Managers, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Registered Dietitians (RDs), Personal Support Workers (PSWs), Maintenance Supervisor, Food Service Supervisor, Food Manager, Resident Assessment Instrument (RAI) Coordinator, Staffing Clerk, Infection Prevention and Control (IPAC) staff member, Human Resources staff member, residents, and residents' family members.

During the inspection, the Inspectors conducted a walk through of resident care areas, observed staff to resident interactions and the provision of care and services to residents reviewed various home policies and procedures and staff training records and resident health care records.

The following Inspection Protocols were used during this inspection:

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

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 24. (3)	CO #002	2017_616542_0002	617
O.Reg 79/10 s. 49. (2)	CO #003	2017_616542_0002	617
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2017_616542_0002	196

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents that had a weight change of five per cent body weight, or more, over one month, a change of seven and one-half per cent body weight, or more over three months, and a change of ten per cent of body weight, or more, over six months, were assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated.

During stage one of the inspection, resident #011 was identified as requiring further inspection regarding a significant weight change. Inspector #621 reviewed resident #011's electronic weight record, which identified that for a one month period, in the winter of 2016, there was a documented significant weight change.

During the inspection, Inspector #621 reviewed resident #011's electronic health record, including documentation in the progress notes and found no documentation that a referral to the Registered Dietitian (RD) had been made for the documented significant weight change.

In an interview, RD #111 confirmed to the Inspector that resident #011 had a significant weight change during an approximate one month period, in the winter of 2016. In addition, RD #111 identified that an RD referral had not been received from the Registered Nursing staff for the significant weight change and should have, in accordance with the home's policy.

Inspector #621 reviewed the home's policy titled "Weight Changes - LTC 5-10", last revised September 2016, which identified that resident weights were to be measured and recorded monthly after admission, that a weight change of five per cent over a one month period would be identified as significant, and the Registered Nurse (RN) would review any significant weight change by referring to the resident's weight history and recent documentation as needed. Additionally, if after any reweighs there continued to be a significant weight change, the RN was to document the significant weight change in the electronic health record, review the resident's progress notes to determine whether the RD had already assessed the weight change, and if not, proceed with a referral to the RD using the Registered Dietitian Referral form on the Intranet.

During an interview, RN #114 verified with the Inspector that a referral to the RD had not been made for the significant weight change that occurred during an approximate one month period, in the winter of 2016, and could not confirm whether the RD was already

aware. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. During stage one of the inspection, resident #012 was identified as requiring further inspection regarding a significant weight change. Inspector #621 reviewed resident #012's electronic weight record, which identified that during an approximate one month period, in 2017, there was a documented significant weight change.

During the inspection, Inspector #621 reviewed resident #012's electronic health record, including documentation in the progress notes and found no documentation that a referral to the Registered Dietitian (RD) had been made for the documented significant weight change.

In an interview, RD #111 confirmed to the Inspector that resident #012 had a significant weight change during an approximate one month period, in 2017. Additionally, RD #111 identified that an RD referral had not been received from the Registered Nursing staff for the significant weight change, and should have in accordance with the home's policy.

During an interview, RN #114 confirmed to the Inspector that no documentation was found identifying that a referral to the RD was made for the identified significant weight change, or that the RD was already aware. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

3. During stage one of the inspection, resident #013 was identified as requiring further inspection regarding a significant weight change. Inspector #621 reviewed resident #013's electronic weight record, which identified that during an approximate one month period, in 2017, there had been a documented significant weight change.

During the inspection, Inspector #621 reviewed resident #013's electronic health record, including documentation in the progress notes and found no documentation that a referral to the Registered Dietitian (RD) had been made for the documented significant weight change.

In an interview, RD #111 confirmed to the Inspector that resident #013 had a significant weight change during an approximate one month period, in 2017. Additionally, RD #111 identified that an RD referral had not been received from the Registered Nursing staff for the significant weight change, and should have in accordance with the home's policy.

During an interview, RN #114 confirmed to the Inspector that there was no documentation identifying that a referral to the RD was made for the identified significant

weight change, or that the RD was already aware.

During interviews with RN #112, and with RN's #113 and #114, it was reported to Inspector #621 that the RN was responsible for printing off a weight report for significant weight changes after the 15th of every month and to review residents identified on the report as having a significant weight change of five per cent or more weight gain or loss compared to the previous month. The RNs also reported that if there was a significant weight change identified, that they would review the resident's progress notes to determine if the RD had already assessed the resident for the same issue, before obtaining a re-weigh of the resident to confirm the significant weight change. If after a reweigh the weight change continued to be significant, they identified that they would then send an electronic referral to the RD. RN's #112, #113 and #114 identified to the Inspector that there was currently no consistent process for them to determine if an electronic referral was received by the RD. Additionally, they reported that there was not a consistent process across all units to verify whether or not a referral to the RD was made.

During an interview with Clinical Manager #104, they reported to the Inspector that it was their expectation that significant weight changes were assessed using an interdisciplinary approach, which included the RN following the home's policy and completing a review of the monthly weight reports for their assigned units for significant weight changes. After determining with reweigh that a resident had a continued significant weight change they were to follow up with an electronic referral to the RD for further assessment. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for resident #007 that set out the planned care for the resident.

The home submitted a Critical Incident System (CIS) report regarding an incident that caused injury for which resident #007 was taken to hospital and had resulted in significant change in their health status. The CIS indicated that resident #007 had a fall and was found on the floor. The implemented falls prevention device did not alert the staff that resident #007 had removed a second safety device. Staff assessed resident #007 as not sustaining an injury and had complained of pain during the night. The following day, resident #007 was transferred to hospital for assessment and determined that resident #007 had a significant injury.

Inspector #617 reviewed resident #007's care plan that was in effect at the time of their fall, which indicated they required assistance of staff for transfer, was at risk of falls and had specific fall interventions to prevent injury. A review of the interventions did not include the use of the first falls prevention device.

Inspector interviewed the RAI (Resident Assessment Instrument) Coordinator #129 who confirmed that prior to resident #007's fall on that specific date, the care plan that was reviewed was in place at the time of the fall.

Inspector #617 interviewed RPN #130 who reported that resident #007 was admitted to

the home in 2017, and assessed as a risk for falls. The Inspector interviewed PSW #131 who reported that prior to the resident's fall they required the use of a falls prevention device because they had a physical condition. The Inspector interviewed PSW #132 who reported that prior to the resident's fall, they required the assistance of staff for transfer and they had a physical and cognitive condition. As a result resident #007 required the use of a falls prevention device to alert staff to come to their assistance.

A review of resident #007's progress notes indicated that the use of the falls prevention device was initiated five days prior to their fall. In addition, RN #113 documented that resident #007's Substitute Decision Maker (SDM) agreed with the use of a falls prevention device to maintain their safety. Two days prior to their fall, RN #132 documented that resident #007 was found to have transferred self and the falls prevention device did not sound. [s. 6. (1) (a)]

2. During stage one of the inspection, resident #016 was identified as requiring further inspection regarding responsive behaviours.

During the inspection, Inspector #577 reviewed resident #016's progress notes and found that the resident had multiple incidences of responsive behaviours towards staff and co-residents over an approximate six month time period. The progress notes revealed specific information regarding the incidences.

The RAI Coordinator #129 provided Inspector #577 with the resident's care plan in effect for a three month period in which the resident had incidences of responsive behaviours. The care plan did not contain a focus or any interventions related to managing responsive behaviours towards staff and co-residents.

A review of the home's policy titled "Plan Of Care – LTC 2-20" last revised February 2016, indicated that the plan of care was to be reviewed and revised according to reassessment in collaboration and consent with the resident/SDM:
-at a minimum quarterly
-and with any change in condition, risk level and/or functional ability
-changes are communicated to all staff involved with the care of the resident.

During an interview with PSW #133, they reported that the resident had specific responsive behaviours towards staff during care. They further reported that the resident had specific responsive behaviours towards co-residents. The PSW reported to the Inspector the interventions that they used to address the resident's specific responsive

behaviours.

During separate interviews with RPN #122 and PSW #134, they reported that the resident had specific responsive behaviours towards staff and co-residents.

During an interview with Clinical Manager #104, they confirmed that there were no further revisions to the care plan related to specific responsive behaviours until the day before this interview. They further confirmed that registered nursing staff were responsible for updating residents care plans to reflect the planned care for the resident. [s. 6. (1) (a)]

3. The licensee failed to ensure that the provision of the care set out in the plan of care was documented.

During stage one of the inspection, residents #004 and #008 were identified as requiring further inspection regarding oral care.

During the inspection, Inspector #577 conducted a record review of resident #004's flow sheet for an approximate one month period in 2017, related to oral care that revealed the following:

- for 17 days there was no documentation for mouth care
- for 16 days there was no documentation for teeth being cleaned

During the inspection, Inspector #577 conducted a record review of resident #008's flow sheet for an approximate one month period in 2017, related to oral care that revealed the following:

- for 16 days there was no documentation for mouth care
- for 7 days there was no documentation for denture care

During an interview with Clinical Manager #104, they confirmed the missing documentation for both resident's oral care. They further confirmed that staff were expected to document their care daily, and when it was completed. [s. 6. (9) 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 that ensures there is a written plan of care for resident #007 and resident #016 that sets out the planned care for the resident, that the provision of the care set out in the plan of care for resident #004 and resident #008 is documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On a specific date in 2017, a Critical Incident System (CIS) report was submitted to the Director for an incident of alleged staff neglect of resident #020, resident #021 and resident #022, which had occurred on a specific date.

The Administrator reported during an interview with Inspector #196, that PSW #126 had sent an email to Clinical Manager #103 and Acting Clinical Manager #124 late in the evening in which the incident of potential neglect had occurred.

An interview was conducted with the Acting Clinical Manager #124 who reported that they became aware of the incident of alleged neglect of residents on the following day, at which time the DOC was informed and the home's investigation was initiated.

The licensee's policy "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications about Incidents of Abuse or Neglect - LTC 5-51", approved February 2016, identified that "the Director/designate and/or VP Senior's Health must be notified immediately and they will notify the Ministry by phone."

A review of online reporting identified that the Vice President of Seniors Services #125 reported the incident via the after hours pager for the Ministry, four days after Acting Clinical Manager #124 had become aware of the incident. [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 that ensures a person who had 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: 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, to be implemented voluntarily.

WN #4: 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 his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items.

During stage one of the inspection, Inspector #621 observed unlabelled personal care items in the following resident spa rooms:

Spa A:
- three used "Secret" deodorant sticks on the counter
- one used blue disposable razor on the counter

Spa B:
- three used "Secret" deodorant sticks in the drawers

- four nail clippers used on top of nail clipper caddy

During the inspection, Inspector #621 interviewed PSW #100 who was present in the spa room at the time of inspection and confirmed to the Inspector that products identified were used, unlabelled, and should have been labelled to determine correct resident use.

During stage one of the inspection, Inspector #617 observed unlabelled personal care items in the following resident spa rooms:

Spa C:
- one used "Secret" deodorant stick found in a drawer
- one black comb pick with dandruff found in a drawer
- one green comb with hair found in a drawer
- one black comb with hair found in a drawer

Spa D:
- two silver brushes with hair sitting on the counter

Spa E:
- two used "Secret" deodorant sticks found in the drawer
- one grey brush with hair found in the drawer

Spa F:
- three used black combs with hair and dandruff found in the drawer

Spa G:
- one used old spice deodorant stick found in a drawer
- five black combs with hair found in a drawer
- one silver brush with hair found in a drawer
- one pink brush with hair on the counter

Spa H:
- one blue brush with hair found on the counter
- one used purple "Lady Speed" stick found in a drawer

Spa I:
- one green comb with hair on found on the counter
- one silver brush with hair found in the drawer

Inspector #617 interviewed PSW #102 who reported that resident personal products such as combs, brushes, nail clippers and deodorant should be labelled if left in the spa room to ensure that they are used on the correct resident.

Inspector #617 requested the home's policy regarding labeling of personal items for residents from both RPN #101 and Clinical Manager #103 and they were not able find the home's policy.

Inspector #617 interviewed Clinical Manager #103 who explained that it was the PSW's responsibility to have labeled all hair brushes, nail clippers, and deodorant used in the spa rooms as these items were not to be used communally. [s. 37. (1) (a)]

2. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids cleaned as required.

During stage one of the inspection, Inspector #621 observed resident #002's wheelchair with multiple dried spill stains on the chair pad and arm rests; and resident #003's wheelchair seat pad soiled with food debris on the right front corner.

On another day during stage one of the inspection, Inspector #621 observed the seat belt on resident #001's wheelchair to be stained with old food debris.

On another day during the inspection, Inspector #621 observed resident #001 in their wheelchair and noted old food stains and debris on the seat belt, dried food debris and stains on the chair pad, arm rests and metal frame. Inspector #621 also observed resident #002's wheelchair with dried spill stains on the chair pad and arm rests; and resident #003's wheelchair with food debris soiled into the right front corner of the seat pad.

During an interview with PSW #115 and RPN #108, they reported that resident wheelchairs were to be cleaned monthly on night shift or more often if visibly soiled by PSW staff, and that PSW staff followed the wheelchair and walker cleaning schedule and procedures document found in the pre-start check binder on each unit. It was identified that wheelchairs and walkers were machine cleaned using either of two mechanical washers found on specific units in the resident home areas. Additionally, it was identified that PSW staff would document on the monthly wheelchair/walker washer list to identify when a resident's wheelchair or walker was cleaned.

Inspector #621 reviewed March 2017 Wheelchair/Walker Washing Schedule for one specific unit, and it was noted that resident #001's wheelchair was to be cleaned on a particular day, but there was no documentation that this had been completed on that date, or any date thereafter.

In an interview, RPN #108 reported that resident #001's wheelchair was supposed to be cleaned on a specific date in March 2017, and there was no documentation identifying that this resident's chair was cleaned.

On that same day, RPN #108 observed resident #001's wheelchair and confirmed to the Inspector that the wheelchair seat pad, seat belt and metal frame were soiled with food debris and required cleaning.

On another day, Inspector #621 reviewed the March 2017 Wheelchair/Walker Washing Schedule for another unit, and noted that resident #003's wheelchair was to be cleaned on a particular date in March 2017, and there was no documentation that cleaning of resident #003's wheelchair had been completed.

In an interview, RPN #116 reported that resident #003's wheelchair was supposed to be cleaned on a specific date in March 2017, that there was no clear documentation identifying that this resident's chair was cleaned.

On that same day, RPN #116 observed resident #003's wheelchair and confirmed to the Inspector that the wheelchair seat pad was visible soiled and should have been spot cleaned by the PSW staff.

On another day, Inspector #621 reviewed the March 2017 Wheelchair/Walker Washing Schedule for another unit, and it was noted that resident #002's wheelchair was cleaned in March 2017, however, there was no date recorded as to when cleaning of resident #002's wheelchair had been completed.

On that same day, RPN #117 reported that resident #002's wheelchair was supposed to be cleaned in March 2017, that the record identified that a PSW had cleaned this resident's wheelchair, however there was no date identifying when during the month this had occurred.

On that same day, RPN #117 observed resident #002's wheelchair and confirmed to the

Inspector that the wheelchair was visibly soiled with food debris and stains on the arm rests, metal frame and seat cover.

During an interview with Clinical Manager #104 they reported to Inspector #621 that it was their expectation that residents personal aids including wheelchairs were cleaned monthly as per the cleaning schedule located on each unit, or more often if required (PRN). [s. 37. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items and personal aids are cleaned as required, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication

cart that was secured and locked.

During stage one of the inspection, Inspector #621 observed one tube of topical prescription cream on the counter in one of the spa rooms. The tube had a prescription label identifying the name of the medication, resident #024's name and instructions for its application.

During resident interviews for stage one of the inspection, Inspector #617 observed the following topical prescription creams in the resident rooms:

-one small white container observed on resident #008's bedside table in a resident room with a prescription label identifying the name of the medication with resident #008's name and instructions for its application, and

-one small white container observed on resident #011's bedside table in a resident room with a prescription label identifying the name of the medication with resident #001's name and instructions for its application.

On another day during the inspection, Inspector #617 observed one small white container of topical prescription cream on the counter beside the sink in resident #006's bathroom. The container had a prescription label identifying the name of the medication with resident #006's name and instructions for application.

On another day during the inspection, Inspector #617 interviewed PSW #105 who attended resident #006's bathroom and acknowledged that the topical prescription cream was sitting on the counter in the bathroom beside their sink. PSW #105 further reported that all treatment creams were to be kept locked in the medication room when not in use and clarified that it should not have been left in resident #006's room.

The health care record for residents #024, #008, #011, and #006 were reviewed by the Inspector and physician's orders with instructions to keep these prescription topical creams at the bedside of the respective residents were not present.

Inspector #617 interviewed both RPNs #106 and #107 who reported that resident topical prescription creams were to be kept in the locked medication room when not in use. Both RPNs explained that PSWs were responsible to apply the topical prescription creams to the residents and then return them to the RPNs for safe storage in the medication room.

Inspector #617 interviewed Clinical Manager #104 who confirmed that topical prescription creams were to be kept locked in the medication rooms when not in use and clarified that they were not to be left in the resident rooms or spas. [s. 129. (1) (a)]

2. On a particular date during the inspection, on a specific unit, Inspector #196 observed a green plastic storage container of prescription creams and topical medications, labeled with resident room numbers on the nursing desk. Within the storage container, there was:
- two types of topical prescription creams for resident #028
- prescription shampoo for resident #029
- topical prescription cream container for resident #030
- two containers of topical prescription creams for resident #031

An interview was conducted with PSW #136 who reported that the topical medications were to be kept in the medication room. [s. 129. (1) (a) (ii)]

Additional Required Actions:

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

WN #6: 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 a drug was administered to resident #023 in accordance with the directions for use specified by the prescriber.

A Critical Incident System (CIS) report was submitted to the Director on a specific date in 2017, related to a medication incident that occurred with the administration of resident #023's prescribed medication. The CIS indicated that on a specific date in 2017, RPN #122 acknowledged that resident #023 was given incorrect dosages of their prescribed medication over the course of four days which caused untoward effects for the resident. Resident #023 was assessed by the Nurse Practitioner on that specific date in 2017, and did not require transfer to hospital for assessment.

A review of resident #023's Medication Administration Record (MAR), dated for a one month period in 2017, the physician's order and the prescription medication, all indicated that starting on a specific date the resident was to be administered an amount of medication once a day. Registered staff documentation on resident #023's MAR confirmed that the resident had been administered the medication once a day at a specific time for four consecutive days in 2017.

A review of the home's investigation notes indicated that resident #023 was to be administered an amount of medication each day over the four days. The home's investigation notes further determined that over these four days resident #023 was administered a greater amount of the medication than prescribed. In addition, the home's investigation did not determine if it was multiple registered staff members or only one RPN who had administered an incorrect dosage of the medication or when the incorrect dose(s) were given.

On April 3, 2017, Inspector #617 interviewed the Administrator who reported that the home's investigation did conclude resident #023 was administered an overdose of their medication. [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 that ensures that a drug is administered to resident #023 in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On two particular dates, during the inspection, Inspectors #617 and #621 respectively observed on one unit, a significant amount of black scuff marks measuring two meters long by 0.7 meters high and 1.3 meters long by 0.7 meters high on the drywall adjacent to the dining room below the bulletin board, and on the wall to the left side of the fire doors entering into the corridor in which resident rooms were situated. In addition to scuff marks, the corners of both walls had significant drywall damage, including gouges measuring 20 centimeters in length by 30 centimeters in height.

On these same dates, Inspectors #617 and #621 respectively observed on another unit, between resident rooms, wall damage in the form of exposed drywall and missing paint, measuring four centimeters wide by 10 centimeters long, and black scuff marks along the

length of the wall at baseboard level measuring 2.7 meters long.

On another date, Inspector #621 observed on another unit, a puncture hole in the drywall measuring five centimeters squared between rooms.

On two other particular dates, Inspectors #617 and #621 respectively observed on another unit, across from a resident room, drywall damage with gouges measuring ten centimeters wide by 15 centimeters high, and numerous black scuff marks along length of wall measuring five meters in length.

On another date, Inspector #621 observed on another unit, a resident room door frame, missing paint and dry wall damage measuring four centimeters wide by 15 centimeters in length.

On another date, Inspector #621 observed on another unit, wall damage in the form of exposed drywall and missing paint on both sides of the doorway for a resident room.

During an interview with Inspector #621, RPN #108 and PSW #109 reported that unit staff, including registered and non-registered staff utilized the Maintenance Request log book to record maintenance issues identified. Additionally, they reported that each day the Ward Clerk for each unit documented the maintenance issues from the log book using the electronic work order application, to the maintenance department.

Inspector #621 reviewed the Maintenance Request log book on four different units, over the approximate three month time period, and found no wall damage issues documented.

RPN #108 verified the wall damage in the dining room of one of the units with Inspector #621 and identified that staff may not be reporting wall damage to maintenance as it becomes normalized within the environment and no longer obvious to them. RPN #108 further indicated that the damage observed was significant and should have been reported as part of the maintenance reporting process.

During an interview with Maintenance Supervisor #110 it was reported to Inspector #621 that the maintenance department was aware of the wall disrepair throughout the home; that there was no formal preventative maintenance process or auditing being completed to identify wall damage; and that maintenance staff were doing "touch ups" of painting and dry wall repair as they came across it, with a focus on fixing damage in common

areas of the home. Maintenance Supervisor #110 confirmed the wall damage found by Inspectors #617 and #621 during the inspection.

During an interview with Clinical Manager #104, it was reported to Inspector #621 that it was their expectation that all maintenance concerns, including wall damage should be documented by PSW and RPN staff in the Maintenance log book on each unit, and issues processed by the Ward Clerk each day to Maintenance using the electronic requisition form. [s. 15. (2) (c)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis.

During observations on a specific date during the inspection, Inspector #577 found resident #001's clothes to be unclean. Their shirt and pants were soiled with food stains.

A review of resident #001's care plan indicated a significant medical condition, and the care plan focus regarding hygiene included the nursing intervention which indicated the total assistance of one staff. [s. 32.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #007 had fallen, and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A Critical Incident System (CIS) report was submitted to the Director regarding an incident that caused injury for which resident #007 was taken to hospital and resulted in significant change in their health status. The CIS indicated that resident #007 had an unwitnessed fall on a specific date in 2017.

During the inspection, Inspector #617 reviewed resident #007's health care record and found that a post fall assessment for their fall on that specific date, had not been completed.

During the inspection, the Inspector interviewed RPN #130 who reported that it was the RN or RPN's responsibility to complete a post fall assessment on line in the electronic documentation system (Med-e-care) under assessments after a resident has fallen to determine if the care plan needs to be updated.

The Inspector interviewed Clinical Manager #104 who reviewed resident #007's assessments in Med-e-care and confirmed to the Inspector that a post fall assessment for the resident's fall on the recorded date had not been completed until it was brought to their attention by the Inspector. In addition, they reported that the post fall assessment should have been completed on the date of the fall. [s. 49. (2)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, communication of the seven-day and daily menus to residents.

During a tour of the home, Inspector #621 observed the posting of a seven-day menu in one of the units dining room, but no daily menu was noted.

During the lunch meal service on a specific date, between 1200 and 1300hrs, Inspector #621 observed PSWs #118, #100, and #119 serving soup to residents seated in the unit dining room, and there was no communication to residents as to what kind of soup was being offered.

During an interview with the Dietary Aide #120, it was reported to the Inspector that the daily menu could be found on the television situated in the unit dining room adjacent to the servery. Dietary Aide #120 identified that the television was turned on every morning by the Dietary Aide before breakfast service so that residents could see the menu for that day.

On a specific date, between 0930 and 1300hrs, Inspector #621 observed the same unit's dining room television to be turned off, with the daily menu not visible within the unit.

At 1300hrs, that same date, Dietary Aide #120 acknowledged the dining room television to be off and no daily menu visible. Dietary Aide #120 further identified that that they had been responsible to turn the television on to the daily menu that morning, but identified that they were unsure how to do this.

During an interview with Food Services Supervisor #121, they indicated to the Inspector that it was their expectation that the prior to breakfast meal service each day, the assigned Dietary Aide for each resident home area turned on the dining room television and updated the daily menu so that was visible for residents. [s. 73. (1) 1.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a report is made to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: A description of the individuals involved in the incident, including, names of any staff members or other persons who were present at or discovered the incident.

On a specific date, a Critical Incident System report (CIS) was submitted to the Director for an incident of alleged staff to resident abuse/neglect towards resident #020, resident #021 and resident #022, which had occurred on a specific date in 2017.

The report was reviewed by Inspector #196 and the Administrator and they confirmed to the Inspector that the report did not identify the name of the staff member that was alleged to neglect the residents.

An interview was conducted with Clinical Manager #124 who had submitted the CIS report. They reported that they did not include the name of the alleged staff member as the incident of neglect towards the residents had not been verified.

According to the Administrator, the name of all staff members that were present at the time of the incident were to be included in the CIS report, whether or not the incident had been verified. [s. 104. (1) 2.]

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. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that on every shift, the symptoms of infection were recorded and immediate action was taken as required.

During stage one of the inspection, resident #010 was identified through a Minimum Data Set (MDS) assessment as requiring further inspection regarding a previous infection.

Inspector #617 reviewed the health care records for resident #010. The Minimum Data Set (MDS) dated on a specific date in 2017, indicated that they had a particular type of infection during a period of three months in fall 2016/winter 2017. The progress notes dated from a specific date in 2017, indicated that resident #010 had particular symptoms of infection. The physician's order dated a specific date indicated a treatment of medication for a time period for the infection.

Inspector interviewed RPN #117 who confirmed that resident #010 was symptomatic with a infection, treated with medication and was included as part of one of the home units disease outbreak in a specific month of 2017. Inspector interviewed Infection Prevention and Control (IPAC) staff member #135 who confirmed that resident #010 met the Thunder Bay District Health Unit's case identification for the home's outbreak starting on a specific date in 2017, and received treatment. Both RPN #117 and IPAC staff member #135 reported to the Inspector that signs and symptoms of infection were to be documented in the resident's progress notes, on every shift, if an active infection was present, especially during a outbreak to determine their inclusion on the infection outbreak listing.

Inspector reviewed the progress notes dated from over a 14 day period in 2017, during the time resident #010 was first identified as symptomatic with an infection, treated with medication and specific precautions. The progress notes on nine of the 14 day period did not include the recording of symptoms of infection on every shift.

Inspector interviewed both RPN #117 and Clinical Manager #104 who reviewed resident #010's progress notes with the Inspector dated from over the 14 day period in 2017 and confirmed to the Inspector that documentation of resident #010's signs and symptoms for their infection was missing when their active infection was present. [s. 229. (5) (b)]

Issued on this 25th day of May, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAUREN TENHUNEN (196), DEBBIE WARPULA (577), JULIE KUORIKOSKI (621), SHEILA CLARK (617)
Inspection No. / No de l'inspection :	2017_624196_0005
Log No. / Registre no:	005992-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 16, 2017
Licensee / Titulaire de permis :	ST. JOSEPH'S CARE GROUP 35 NORTH ALGOMA STREET, P.O. BOX 3251, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	HOGARTH RIVERVIEW MANOR 300 LILLIE STREET, THUNDER BAY, ON, P7C-4Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pamela Nisbet

To ST. JOSEPH'S CARE GROUP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee is ordered to ensure that resident #011, resident #012 and resident #013, and all residents, with weight changes as identified in O.Reg.79/10, s.69, are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. Provide training to the registered staff members regarding the home's written policy "Weight Changes - LTC 5-10" and the process in which a referral is to be made to the Registered Dietitian (RD). The home is to keep a record of who provided the training, the content and dates of the training and the names of the attendees.

2. Ensure that the registered staff members document and process referrals to the Registered Dietitians as required.

3. Conduct monthly audits of significant resident weight changes to evaluate the training of the registered nursing staff members and to ensure the home's policy is being followed.

Grounds / Motifs :

1. The licensee has failed to ensure that residents that had a weight change of

five per cent body weight, or more, over one month, a change of seven and one-half per cent body weight, or more over three months, and a change of ten per cent of body weight, or more, over six months, were assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated.

During stage one of the inspection, resident #011 was identified as requiring further inspection regarding a significant weight change. Inspector #621 reviewed resident #011's electronic weight record, which identified that for a one month period, in the winter of 2016, there was a documented significant weight change.

During the inspection, Inspector #621 reviewed resident #011's electronic health record, including documentation in the progress notes and found no documentation that a referral to the Registered Dietitian (RD) had been made for the documented significant weight change.

In an interview, RD #111 confirmed to the Inspector that resident #011 had a significant weight change during an approximate one month period, in the winter of 2016. In addition, RD #111 identified that an RD referral had not been received from the Registered Nursing staff for the significant weight change and should have, in accordance with the home's policy.

Inspector #621 reviewed the home's policy titled "Weight Changes - LTC 5-10", last revised September 2016, which identified that resident weights were to be measured and recorded monthly after admission, that a weight change of five per cent over a one month period would be identified as significant, and the Registered Nurse (RN) would review any significant weight change by referring to the resident's weight history and recent documentation as needed. Additionally, if after any reweighs there continued to be a significant weight change, the RN was to document the significant weight change in the electronic health record, review the resident's progress notes to determine whether the RD had already assessed the weight change, and if not, proceed with a referral to the RD using the Registered Dietitian Referral form on the Intranet.

During an interview, RN #114 verified with the Inspector that a referral to the RD had not been made for the significant weight change that occurred during an approximate one month period, in the winter of 2016, and could not confirm whether the RD was already aware. (621)

2. During stage one of the inspection, resident #012 was identified as requiring further inspection regarding a significant weight change. Inspector #621 reviewed resident #012's electronic weight record, which identified that during an approximate one month period, in 2017, there was a documented significant weight change.

During the inspection, Inspector #621 reviewed resident #012's electronic health record, including documentation in the progress notes and found no documentation that a referral to the Registered Dietitian (RD) had been made for the documented significant weight change.

In an interview, RD #111 confirmed to the Inspector that resident #012 had a significant weight change during an approximate one month period, in 2017. Additionally, RD #111 identified that an RD referral had not been received from the Registered Nursing staff for the significant weight change, and should have in accordance with the home's policy.

During an interview, RN #114 confirmed to the Inspector that no documentation was found identifying that a referral to the RD was made for the identified significant weight change, or that the RD was already aware. (621)

3. During stage one of the inspection, resident #013 was identified as requiring further inspection regarding a significant weight change. Inspector #621 reviewed resident #013's electronic weight record, which identified that during an approximate one month period, in 2017, there had been a documented significant weight change.

During the inspection, Inspector #621 reviewed resident #013's electronic health record, including documentation in the progress notes and found no documentation that a referral to the Registered Dietitian (RD) had been made for the documented significant weight change.

In an interview, RD #111 confirmed to the Inspector that resident #013 had a significant weight change during an approximate one month period, in 2017. Additionally, RD #111 identified that an RD referral had not been received from the Registered Nursing staff for the significant weight change, and should have in accordance with the home's policy.

During an interview, RN #114 confirmed to the Inspector that there was no documentation identifying that a referral to the RD was made for the identified significant weight change, or that the RD was already aware.

During interviews with RN #112, and with RN's #113 and #114, it was reported to Inspector #621 that the RN was responsible for printing off a weight report for significant weight changes after the 15th of every month and to review residents identified on the report as having a significant weight change of five per cent or more weight gain or loss compared to the previous month. The RNs also reported that if there was a significant weight change identified, that they would review the resident's progress notes to determine if the RD had already assessed the resident for the same issue, before obtaining a re-weigh of the resident to confirm the significant weight change. If after a reweigh the weight change continued to be significant, they identified that they would then send an electronic referral to the RD. RN's #112, #113 and #114 identified to the Inspector that there was currently no consistent process for them to determine if an electronic referral was received by the RD. Additionally, they reported that there was not a consistent process across all units to verify whether or not a referral to the RD was made.

During an interview with Clinical Manager #104, they reported to the Inspector that it was their expectation that significant weight changes were assessed using an interdisciplinary approach, which included the RN following the home's policy and completing a review of the monthly weight reports for their assigned units for significant weight changes. After determining with reweigh that a resident had a continued significant weight change they were to follow up with an electronic referral to the RD for further assessment.

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 residents #011, #012 and #013 and all other residents' health and safety. The scope was determined to be a pattern and the home continues to have ongoing non-compliance in this area of the legislation. There is a history of previous non-compliance identified during the following inspections:
- A voluntary plan of correction (VPC) was issued during the Resident Quality Inspection #2016_435621_0012 served to the home on November 25, 2016;
- A voluntary plan of correction (VPC) was issued during a Complaint Inspection #2016_333577_0011 served to the home on May 25, 2016;
- A voluntary plan of correction (VPC) was issued during the Resident Quality

Inspection #2015_333577_0012 served to the home on October 9, 2015. (621)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 04, 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 16th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lauren Tenhunen

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