Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133


## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 11, 2019 | 2018_752627_0024 | 018445-18 | Follow up |

### Licensee/Titulaire de permis

Board of Management for the District of Nipissing West
100 Michaud Street STURGEON FALLS ON P2B 2Z4

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

Au Chateau
100 Michaud Street STURGEON FALLS ON P2B 2Z4

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

SYLVIE BYRNES (627)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Follow up inspection.**

**This inspection was conducted on the following date(s): November 5-9, 13-16 and 19-23, 2018.**

**A Critical Incident System Inspection, #2018_752627_0025 and a Complaint Inspection # 2018_752627_0023 were completed concurrently with this Follow Up Inspection. Please see these reports for further non-compliance issued.**

**CO #001 from Inspection report #2018_657681_0014, s. 6 (7) of the Long-Term Care Homes Act, specific to plan of care, was inspected during this Follow Up inspection.**

**Inspector Steven Naccarato (#744) attended this inspection, along with Inspector #627.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Coordinator of Resident Services (CRS), Environmental Service Manager (ESM), Dietary Manager (DM), Physiotherapist (PT), Pastoral Care, Physiotherapist Assistants (PTAs), Dietary Aides (DAs), Housekeeping staff (HS), Pharmacy Assistant, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and families.**

**The inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, internal investigation notes, policies, procedures and programs.**

**Ad-hoc notes were used during this inspection.**

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (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).**

**Findings/Faits saillants :**

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.

The following compliance order (CO #001) from Inspection 2018_657681_0014, was made under, s. 6 (7), LTCHA.

Specifically, the licensee was to ensure that staff provided care to resident #001 and all other residents, as outlined in the plan of care.

A critical incident system (CIS) report was submitted to the Director alleging staff to resident neglect. The CIS report indicated that Personal Support Worker (PSW) #132 had not provided care to resident #014.

Inspector #627 reviewed resident #014's care plan in effect at the time of the incident and noted for the focus of activities of daily living (ADLs), that resident #014 required a specific level of assistance during certain times of the day.

Inspector #627 interviewed PSW #132 who stated that they had been surprised by the allegations. The PSW stated that resident #014 was capable of completing a certain level of their care. PSW #132 stated that they had observed supplies for the ADL and had assumed that it had been completed. PSW #132 had been hesitant not to let the resident do what they were capable of, and that there may have been a "blip" in the conversation.

Inspector #627 interviewed the Director of Care (DOC) who stated that there had been a lack of communication between resident #014 and PSW #132; consequently, resident #014 had not been provided with the care they required. The DOC acknowledged that care was not provided to resident #014 as indicated in their care plan.

The previous is further evidence to support CO #001, from inspection report 2018_657681_0014. [s. 6. (7)]

2. A CIS report was submitted to the Director alleging staff to resident neglect. The CIS report indicated that PSW #130 had refused to assist resident #015 with an ADL.

Inspector #627 interviewed resident #015 who stated that they had rung their bell to request assistance, and that they were told by PSW #130, that they were too tired to assist them. Resident #015 stated that they had reported the incident to the following

shift staff.

Inspector #627 reviewed resident #015's written care plan in effect at the time of the alleged incident. The focus of ADLs indicated that resident #015 required assistance for a specified ADL and that staff were to provide assistance throughout the day, with the specific ADL.

Inspector #627 interviewed PSW #128 who stated that resident #015 had informed them of the incident. They felt this needed to be reported. PSW #128 stated they had asked a co-worker, PSW #131, to ask resident #015 what had occurred. The resident had repeated the same allegations to PSW #131.

Inspector #627 interviewed the DOC who stated that they had spoken to resident #015 and the resident had provided the same details to them as they had to other staff members. The DOC acknowledged that the resident had not received care as was indicated in their care plan and that PSW #130 had received disciplinary action. [s. 6. (7)]

3. A complaint was submitted to the Director regarding concerns about restraints.

Inspector #627 interviewed resident #003's family member who indicated that the resident was to have their restraint removed and provided with a specific intervention; however, they had been informed by staff that this was not occurring.

On two separate dates, Inspector #627 observed resident #003 in the dining room for a meal service. The resident was observed at the dining room table, with specific restraints in place.

Inspector #627 reviewed resident #003's care plan in effect at the time of the Inspection. Under the focus of physical restraint, it was indicated that resident #003 was to have their restraints removed during meals.

Inspector #627 interviewed PSW #110 who stated that resident #003 should not have been restrained during a meal service.

Inspector #627 interviewed RN #119 who stated that resident #003 was not to be restrained while in the dining room, as more staff were available to supervise resident #003. [s. 6. (7)]

4. A complaint was submitted to the Director regarding concerns about restraints. Please see previous item for details.

Inspector #627 observed resident #003 being assisted to the TV room after a meal service, at a specific time, where they remained sitting, restrained, until they were brought to the dining room for the following meal service. They were returned to the TV room after the meal service. Resident #003 had been in their restraint for a period of five hours.

On a later date, resident #003 was observed being assisted to their room after the meal service. The resident remained with their restraint applied; the resident was not repositioned during the observation.

Inspector #627 reviewed resident #003's care plan in effect at the time of the inspection. Under the focus of physical restraints, the care plan indicated that the resident should have been provided with a specific intervention (that involved removing the restraint), at specified times, throughout the day.

During separate interviews with PSW #104 and #110, they stated to Inspector #627 that resident #003 was usually not provided with the intervention due to workloads and time constraints.

Inspector #627 interviewed Registered Nurse (RN) #119 who stated that according to the staffing plan, it was not possible to meet all the residents' care needs. They further stated "we try to give the care, but I will not lie, I do not have enough staff". RN #119 further stated that they had discussed this with management, but management had said that they had the correct amount of staff for the specific floor. [s. 6. (7)]

5. On a specified date, Inspector #627 observed resident #004 in the dining room during a meal service. Resident #004 was observed eating a few spoonfuls of their meal item. No assistance was provided to the resident. The item was removed with more than 50 per cent not consumed.

Inspector #627 observed resident #004 at a later meal service. A staff member at the table provided cuing for the resident to eat; however, the resident was not provided with physical assistance to eat their meal.

On a later date, during a meal service, resident #004 was observed at the dining room

table with their meal. Inspector #627 observed PSW #106 feeding a spoonful to the resident while standing. PSW #106 stated that resident #004 was independent to eat and feeding them a spoonful of food provided them with encouragement to eat and that they (PSW #106) were "pretty sure" this was what was indicated in their plan of care.

On a later date, during a meal service, Inspector #627 observed resident #004 being provided with their main course. The previous course, which had approximately 10 per cent consumed by the resident, was removed. The resident was observed playing with their main course, but not consuming it.

On another date, during a meal service, resident #004 was in the dining room being assisted with their meal by their family member. The resident was observed eating over 70 per cent of their meal, and a dessert.

Inspector #627 reviewed the care plan in effect at the time of the inspection which indicated that the resident needed a specific level of assistance when eating.

Inspector #627 reviewed a progress note from the Speech Language Pathologist (SLP), which indicated specific dietary interventions, including the resident be provided with a specific level of assistance with meals by staff.

Inspector #627 reviewed resident #004's monthly weight records and noted their recorded weight indicated a weight change, during a six month period.

Inspector #627 interviewed PSW #140 who stated that resident #004 was provided with assistance, with their meal, when necessary. When Inspector #627 pointed out that the resident had barely touched their meal, and asked what was the indication that the resident required assistance, PSW #140 replied that the Registered Dietitian (RD) had assisted resident #004 with a few bites of their meal. Activity Aide #141, who was assisting other residents at the same table, stated that the resident required a specific level of assistance during meals, which was different from what resident #004's care plan indicated.

Inspector #627 interviewed the RD who stated that resident #004 should have received assistance from one staff member for all meals. [s. 6. (7)]

6. A concern was brought forth to Inspector #627 regarding the care provided to resident #007. The resident's family member stated that resident #007 was on a physiotherapy

program for a specified amount of times per week, with the physiotherapist assistant (PTA), however, this had not occurred. The resident's family member stated that when they asked the PTA why resident #007 had not been provided with physiotherapy services on a certain day, the PTA had made excuses. They further stated that "they could count on one hand the times that the PTA had provided the resident with physiotherapy services".

A) Inspector #627 reviewed resident #007's written plan of care for the focus of "Physiotherapy program", which indicated that resident #007 was to be provided with physiotherapy services, for specific amount of times per week.

Inspector #627 interviewed PTA #112 who stated that resident #007 was receiving physiotherapy services. If a staff member was absent, or when a resident was too tired, they attempted at a later time, however; it was not always possible to reattempt at a later time.

Inspector #627 and PTA #112 reviewed the documentation "Physiotherapy, two month Program Log" which indicated that staff were not available, or staff had no help on 19 occasions, or 42 per cent of the time.

Inspector #627 interviewed the Registered Physiotherapist (PT) who stated that at times there were no staff available to provide resident #007 with physiotherapy services. The PT stated that PTA #112 was assigned to resident #007, however, they also worked elsewhere which limited the time spent in the long-term care home. The PT stated that perhaps the time period needed to be adjusted.

B) Upon further review, Inspector #627 noted that resident #016 was to receive physiotherapy services, for a specific amount of times, every week.

Inspector #627 reviewed the "Physiotherapy, two month Program Log" for a specified time period, and noted that resident #016 had not received physiotherapy services for the specified amount of times per week, at any time.

C) Inspector #627 noted that resident #017 was to receive physiotherapy services, for a specific amount of times per week.

Inspector #627 reviewed the "Physiotherapy two month program log", and noted that resident #017 received physiotherapy services 50 per cent of the specified times. (Days

when the resident was not available were not included).

Inspector #627 interviewed PTA #112, who stated that resident #017 received physiotherapy services, however; the home had been short staffed; therefore, resident #017 received physiotherapy services less often than it was ordered. PTA #112 stated that they tried to meet the minimum requirements and if there was extra time, they went to see residents for further visits, however this had not occurred for resident #017.

Inspector #744 interviewed the PT who stated that the home had not had enough PTAs; two full time PTAs had left and although two part time PTA "had come on board", they were limited in their hours. The PT further stated that if a resident was not available, a further attempt may be made to complete the exercise, however it had not made sense to keep going back to see the same residents as it took time away from the other residents. [744] [s. 6. (7)]

***Additional Required Actions:***

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

---

**Issued on this 29th day of January, 2019**

**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

**Ministère de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**

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

**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) :** | SYLVIE BYRNES (627) |
| **Inspection No. / No de l'inspection :** | 2018_752627_0024 |
| **Log No. / No de registre :** | 018445-18 |
| **Type of Inspection / Genre d'inspection:** | Follow up |
| **Report Date(s) / Date(s) du Rapport :** | Jan 11, 2019 |
| **Licensee / Titulaire de permis :** | Board of Management for the District of Nipissing West<br>100 Michaud Street, STURGEON FALLS, ON, P2B-2Z4 |
| **LTC Home / Foyer de SLD :** | Au Chateau<br>100 Michaud Street, STURGEON FALLS, ON, P2B-2Z4 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Jacques Dupuis |

To Board of Management for the District of Nipissing West, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

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

**Linked to Existing Order / Lien vers ordre existant:** 2018_657681_0014, CO #001;

**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 be compliant with s. 6 (7) of the Long term Care Homes Act.

The licensee is required to prepare, submit and implement a plan for achieving compliance under s.6 (7) of the Long Term Care Homes Act. The plan shall include but not be limited to:

a) a detailed description of the steps that the licensee will take to ensure that the care set out in the plan of care for residents #003, #004, #007, #014, #015, #016 and #017, and all other residents, is provided to the residents as outlined in their plan of care.

b) complete a review of all resident care plans to ensure that the staff are following the care set out in the plan.

c) develop and implement a process to ensure that resident care is provided to the residents as specified in the plan. The process is to include an auditing mechanism that identifies when care is not being provided as specified, who is required to undertake the audit, and the frequency that the audits are to occur.

Please submit the written plan, quoting #2018_752627_0024 and Sylvie Byrnes by email to SudburySAO.moh@ontario.ca, by February 5, 2019.

Please ensure that the submitted written plan does not contain and PI/PHI.

**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.

The following compliance order (CO #001) from Inspection 2018_657681_0014, was made under, s. 6 (7), LTCHA.

Specifically, the licensee was to ensure that staff provided care to resident #001 and all other residents, as outlined in the plan of care.

A CIS report was submitted to the Director alleging staff to resident neglect. The CIS report indicated that PSW #130 had refused to assist resident #015 with an activity of daily living (ADL).

Inspector #627 interviewed resident #015 who stated that they had rung their bell to request assistance, and that they were told by PSW #130, that they were too tired to assist them. Resident #015 stated that they had reported the incident to the following shift staff.

Inspector #627 reviewed resident #015's written care plan in effect at the time of the alleged incident. The focus of ADLs indicated that resident #015 required assistance for a specified ADL and that staff were to provide assistance throughout the day, with the specific ADL.

Inspector #627 interviewed PSW #128 who stated that resident #015 had informed them of the incident. They felt this needed to be reported. PSW #128 stated they had asked a co-worker, PSW #131, to ask resident #015 what had occurred. The resident had repeated the same allegations to PSW #131.

Inspector #627 interviewed the DOC who stated that they had spoken to resident #015 and the resident had provided the same details to them as they had to other staff members. The DOC acknowledged that the resident had not received care as was indicated in their care plan and that PSW #130 had received disciplinary action. [s. 6. (7)]

(627)

2. A complaint was submitted to the Director regarding concerns about

restraints.

Inspector #627 interviewed resident #003's family member who indicated that the resident was to have their restraint removed and provided with a specific intervention; however, they had been informed by staff that this was not occurring.

On two separate dates, Inspector #627 observed resident #003 in the dining room for a meal service. The resident was observed at the dining room table, with specific restraints in place.

Inspector #627 reviewed resident #003's care plan in effect at the time of the Inspection. Under the focus of physical restraint, it was indicated that resident #003 was to have their restraints removed during meals.

Inspector #627 interviewed PSW #110 who stated that resident #003 should not have been restrained during a meal service.

Inspector #627 interviewed RN #119 who stated that resident #003 was not to be restrained while in the dining room, as more staff were available to supervise resident #003. [s. 6. (7)]
(627)

3. A complaint was submitted to the Director regarding concerns about restraints. Please see previous item for details.

Inspector #627 observed resident #003 being assisted to the TV room after a meal service, at a specific time, where they remained, restrained, until they were brought to the dining room for the following meal service. They were returned to the TV room after the meal service. Resident #003 had been in their restraint for a period of five hours.

On a later date, resident #003 was observed being assisted to their room after the meal service. The resident remained sitting with their restraint applied; the resident was not repositioned during the observation.

Inspector #627 reviewed resident #003's care plan in effect at the time of the

inspection. Under the focus of physical restraints, the care plan indicated that the resident should have been provided with a specific intervention, (that involved removing the restraint), at specified times, throughout the day.

During separate interviews with PSW #104 and #110, they stated to Inspector #627 that resident #003 was usually not provided with the intervention due to workloads and time constraints.

Inspector #627 interviewed Registered Nurse (RN) #119 who stated that according to the staffing plan, it was not possible to meet all the residents' care needs. They further stated, "we try to give the care, but I will not lie, I do not have enough staff". RN #119 further stated that they had discussed this with management, but management had said that they had the correct amount of staff for the specific floor. [s. 6. (7)] (627)

4. On a specified date, Inspector #627 observed resident #004 in the dining room during a meal service. Resident #004 was observed eating a few spoonfuls of their meal item. No assistance was provided to the resident. The item was removed with more than 50 per cent not consumed.

Inspector #627 observed resident #004 at a later meal service. A staff member at the table provided cuing for the resident to eat; however, the resident was not provided with physical assistance to eat their meal.

On a later date, during a meal service, resident #004 was observed at the dining room table with their meal. Inspector #627 observed PSW #106 feeding a spoonful to the resident while standing. PSW #106 stated that resident #004 was independent to eat and feeding them a spoonful of food provided them with encouragement to eat and that they (PSW #106) were “pretty sure” this was what was indicated in their plan of care.

On a later date, during a meal service, Inspector #627 observed resident #004 being provided with their main course. The previous course, which had approximately 10 per cent had been consumed by the resident, was removed. The resident was observed playing with their main course, but not consuming it.

On another date, during a meal service, resident #004 was in the dining room

being assisted with their meal by their family member. The resident was observed eating over 70 per cent of their meal, and a dessert.

Inspector #627 reviewed the care plan in effect at the time of the inspection which indicated that the resident needed a specific level of assistance when eating. Inspector #627 noted that the care plan had been updated from a specific level of assistance to another level of assistance, on a specific date, weeks earlier.

Inspector #627 reviewed a progress note, from the Speech Language Pathologist (SLP), which indicated specific dietary interventions, including the resident be provided with a specific level of assistance with meals by staff.

Inspector #627 reviewed resident #004's monthly weight records and noted their recorded weight indicated a weight change, during a six month period.

Inspector #627 interviewed PSW #140 who stated that resident #004 was provided with assistance, with their meal, when necessary. When Inspector #627 pointed out that the resident had barely touched their meal, and asked what was the indication that the resident required assistance, PSW #140 replied that the Registered Dietitian (RD) had assisted resident #004 with a few bites of their meal. Activity Aide #141, who was assisting other residents at the same table, stated that the resident required a specific level of assistance during meals, which was different from what resident #004's care plan indicated.

Inspector #627 interviewed the RD who stated that resident #004 should have received assistance from one staff member for all meals. [s. 6. (7)]

(627)

5. A concern was brought forth to Inspector #627 regarding the care provided to resident #007. The resident's family member stated that resident #007 was on a physiotherapy program for a specified amount of times per week, with the physiotherapist assistant (PTA), however, this had not occurred. The resident's family member stated that when they asked the PTA why resident #007 had not been provided with physiotherapy services on a certain day, the PTA had made

excuses. They further stated that they could "count on one hand the times that the PTA had provided the resident with physiotherapy services".

A) Inspector #627 reviewed resident #007's written plan of care for the focus of "Physiotherapy program" which indicated that resident #007 was to be provided with physiotherapy services, for specific amount of times per week.

Inspector #627 interviewed PTA #112 who stated that resident #007 was receiving physiotherapy services. If a staff member was absent, or when a resident was too tired, they attempted at a later time, however; it was not always possible to reattempt at a later time.

Inspector #627 and PTA #112 reviewed the documentation "Physiotherapy, two month Program Log", which indicated that staff were not available, 42 per cent of the time.

Inspector #627 interviewed the Registered Physiotherapist (PT), who stated that at times there were no staff available to provide resident #007 with physiotherapy services. The PT stated that PTA #112 was assigned to resident #007, however, they also worked elsewhere which limited the time spent in the long-term care home. The PT stated that perhaps the time period needed to be adjusted.

B) Upon further review, Inspector #627 noted that resident #016 was to receive physiotherapy services, for a specific amount of times, every week.

Inspector #627 reviewed the "Physiotherapy, two month Program Log", for a specified time period, and noted that resident #016 had not received physiotherapy services for the specified amount of times per week, at any time.

C) Inspector #627 noted that resident #017 was to receive physiotherapy services, for a specific amount of times per week.

Inspector #627 reviewed the "Physiotherapy two month program log" and noted that resident #017 received physiotherapy services 50 per cent of the specified times. (Days when the resident was not available were not included).

Inspector #627 interviewed PTA #112 who stated that resident #017 received physiotherapy services, however; the home had been short staffed; therefore, resident #017 received physiotherapy services less often than it was ordered. PTA #112 stated that they tried to meet the minimum requirements and if there was extra time, they went to see residents for further visits, however this had not occurred for resident #017.

Inspector #744 interviewed the Physiotherapist (PT) who stated that the home had not had enough PTAs; two full time PTAs had left and although two part time PTA "had come on board", they were limited in their hours. The PT further stated that if a resident was not available, a further attempt may be made to complete the exercise, however it had not made sense to keep going back to see the same residents as it took time away from the other residents. [744] [s. 6. (7)]

The severity of this issue was determined to be a level two, as there was minimal harm or potential for actual harm, for the residents. The scope of the issue was a level three, as it was widespread to multiple residents. The home had a level four compliance history, despite Ministry of Health (MOH) action (VPC, order), noncompliance (NC) continues with original area of NC with this section of the LTCHA that included:

- Compliance order (CO) issued November 30, 2015, with a compliance due date (CDD) of January 1, 2016 (#2015_332575_0017);
- Written notification (WN) issued May 2, 2016, (#2016_425639_0004);
- Voluntary plan of correction (VPC) issued November 22, 2016, #2016_320612_0020);
- VPC issued July 18, 2018, (#2016_680687_0016); and,
- CO issued July 19, 2018, with a CDD date of August 7, 2018 (2018_657681_0014).

(627)

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

## Ordre(s) de l’inspecteur

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

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

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Mar 12, 2019

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

**Issued on this 11th day of January, 2019**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Sylvie Byrnes

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