Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 29, 2019	2019_722630_0016	029561-18, 009395-19, 009396-19, 009397-19, 009399-19, 009400-19, 009475-19	Follow up

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care Woodstock Nursing Home
81 Fyfe Avenue WOODSTOCK ON N4S 8Y2

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

AMIE GIBBS-WARD (630), MELANIE NORTHEY (563), NATALIE MORONEY (610)

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): July 2, 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17 and 18, 2019.

The following Follow-up intake was completed within this inspection related to a Compliance Order (CO) from Resident Quality Inspection #2018_722630_0019: Log #029561-18 for CO #002 related to compliance with the home's written hot

weather policies.

The following Follow-up intake was completed within this inspection related to a Compliance Order (CO) from Critical Incident (CI) Inspection #2019_778563_0013: Log #009475-19 for CO #001 related to compliance with home's written drug destruction and disposal policies.

The following Follow-up intakes were completed within this inspection related to Compliance Orders (COs) from Follow-up Inspection #2019_722630_0005:
Log #009400-19 for CO #001 related to compliance with the plan of care for falls prevention;
Log #009397-19 for CO #003 related to documentation of the care provided related to turn and reposition residents and post-fall assessments;
Log #009399-19 for CO #005 related to the completion of post-fall assessments;
Log #009395-19 for CO #007 related to housekeeping services and the cleanliness of the home;
Log #009396-19 for CO #008 related to laundry services and the availability of linen supplies.

During the course of the inspection, the inspector(s) spoke with the Caressant Care Vice President of Operations, the Caressant Care Regional Director Long-Term Care, the Caressant Care Director of Clinical Services and Education, the OMNI Chief Operating Officer, the OMNI Lead Education/On-site Representative, the Executive Director (ED), the Director of Care (DOC), the Assistant Director of Care (ADOC), a Resident Care Coordinator (RCC), Resident Assessment Instrument (RAI) Co-ordinators, the Nutrition Manager, a Physiotherapist (PT), a MediGas Respiratory Therapist (RT), a MIP Senior Account Manager, a Pinkerton Operations Manager, a Ward Clerk, Registered Nurses (RNs), Registered Practical Nurses (RPNs), agency RNs, agency RPNs, Personal Support Workers (PSWs), Housekeepers, family members and residents.

The inspectors also observed resident rooms and common areas, observed medication disposal areas, observed snack service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed various meeting minutes, reviewed written records of staff education and program evaluations.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Falls Prevention
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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)**

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. 30. (2)	CO #003	2019_722630_0005	630
O.Reg 79/10 s. 49. (2)	CO #005	2019_722630_0005	630
O.Reg 79/10 s. 8. (1)	CO #001	2019_778563_0013	563
O.Reg 79/10 s. 8. (1)	CO #002	2018_722630_0019	610
O.Reg 79/10 s. 87. (2)	CO #007	2019_722630_0005	563
O.Reg 79/10 s. 89. (1)	CO #008	2019_722630_0005	563

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

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

Specifically failed to comply with the following:

s. 6. (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 licensee has failed to comply with Compliance Order (CO) #001 from #2019_722630_0005 issued on April 16, 2019, with a compliance due date of May 31, 2019.

The licensee was ordered to ensure that they were compliant with s 6 (7) of the LTCHA.

Specifically the licensee was ordered to:

a) Ensure that the care set out in the plan of care related to mobility and falls prevention is provided to resident #002 and any other resident in the home, as specified in their plan.

b) Ensure an auditing process is developed and fully implemented to ensure that the plan of care for residents at moderate or high risk for falls are provided to the residents as specified in their plans. This auditing process must be documented including the auditing schedule, the names of the people conducting the audit, the residents who have been audited, the results of the audit and what actions were taken in regards to the audit results.

The home failed to complete steps a) and b).

A) The licensee has failed to ensure the plan of care set out in the plan of care for falls prevention and grooming and hygiene was provided to an identified resident as specified in their plan of care.

On multiple occasions during the inspection, Inspector #563 observed an identified resident without a specific device applied as per the resident's plan of care. Inspector #563 also observed that this resident appeared to not have received grooming and personal hygiene as per their plan of care.

During two of the observations identified staff members were present and acknowledged that the device had not been applied to this resident as per the plan of care

The current electronic care plan documented that this resident was at risk of falls and required a specific device to be in place as part of their falls prevention plan of care. The care plan also documented a focus related to hygiene with a goal to "be neat, clean and odour free" which included specific interventions for this resident.

The Executive Director (ED) was shown multiple pictures taken during the inspection of the resident's grooming and hygiene as well as pictures of the specific device not in use. The ED acknowledged that care set out in the plan of care related to personal hygiene and the use of the device was not provided to this identified resident as specified in the plan. (563)

B) The licensee had failed to ensure that the care set out in the plan of care was provided to another identified resident as specified in the plan related to mobility, transfers and falls prevention.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date related to a fall for this identified resident.

The clinical record for this resident documented that the resident was considered to be at risk for falls and required specific interventions that had been initiated by staff on specific dates. The plan of care for this resident included the use of specific devices and specific interventions from staff related to transferring, mobility and falls prevention.

During an interview with an identified registered nursing staff member they said this resident was considered to be at risk for falls. This staff member said they did not think that a specific device was in place for this resident as they thought the family had opted out. The staff member said that some devices that relied on an alarm were hard for staff to hear and respond to if a resident was located in a room down the hallway.

During an interview with two other identified staff members they said this resident had a fall on a specific date. They said that they did not know if the specific device for falls prevention had been in place at the time of the fall. One staff member said the resident had been found in a specific location alone in their room at the time of the fall.

Based on these interviews and record review, the licensee has failed to ensure that the care set out in the plan of care for this resident's fall prevention was provided to the resident as specified in the plan at the time of their fall on a specific date. (630)

C) The licensee failed to ensure that the care set out in the plan of care related to falls prevention was provided to another identified resident as specified in the plan.

The current care plan for this resident documented they were at high risk of falls and

included that this resident required a specific intervention related to their callbell.

On a specific date Inspector #563 observed this identified resident did not have their callbell in place as was identified in their plan of care.

During an interview and identified staff member said that this resident could verbally communicate their needs and also used the call bell.
The licensee failed to ensure that the call bell was provided to this identified resident as specified in the plan. (563)

D) The licensee has failed to ensure that the care set out in the plan of care for bed mobility was provided to another identified resident as specified in the plan.

This inspection was completed related to a CIS report that was submitted to the MOHLTC on a specific date. A review of the CI report showed that the resident sustained a specific type of injury while in the home.

Review of the resident's care plan showed a specific intervention in place related to bed mobility. It also showed that there was a specific type of assistive bed sheet in place for this resident related to bed mobility and positioning.

On specific dates, Inspector #610 observed this resident without the specific type of assistive bed sheet in place.

During an interview an identified staff member said that this resident should have had the specific type of assistive bed sheet in place. The staff member explained how the assistive bed sheet system worked and that it could only be used by two staff.

During an interview a RAI Coordinator said this resident required the specific type of assistive bed sheet in place with a specific type of assistance from staff for positioning. The RAI Coordinator further said that front line staff had access to the Kardex and that this resident's care plan was updated for the use of this intervention.

During an interview the ED stated it was the home's expectation that staff would be using this type of device for repositioning the resident with two staff. (610)

E) The licensee has failed to ensure the plan of care set out in the plan of care for falls prevention was provided to another identified resident as specified in their plan of care.

During an interview an identified registered nursing staff member told Inspector #630 that this resident had a history of falls related to a specific reason.

On a specific date, Inspector #630 observed that this resident did not have one of the interventions in place as specified in their plan of care for falls prevention. A staff member acknowledged that this was not in place at the time of the observation and then applied the intervention.

The written plan of care for this resident included specific interventions related to mobility and falls risk. The clinical record for this resident documented multiple falls between specific dates. The documentation of the post-fall assessments demonstrated that during some of the falls the interventions were not in place as per the plan of care.

During an interview a Resident Assessment Instrument (RAI) Coordinator said they were familiar with Compliance Order (CO) #001 from #2019_722630_0005 related to the plan of care for residents at risk for falls. The RAI Coordinator said they were familiar with this resident and they were considered to be at high risk for falls and continued to fall related to specific reasons. The RAI Coordinator and Inspector #630 reviewed the post fall assessment for this resident for a specific date, and the RAI Coordinator said that the assessment suggested care had not been provided as per the plan of care at the time of this fall. The RAI Coordinator said that they were involved in helping to develop the plan of care for residents at risk for falls, but had not personally involved in completing audits to ensure the care was provided to the residents.

During an interview a Resident Care Coordinator (RCC) said they were familiar with Compliance Order (CO) #001 from #2019_722630_0005 related to the plan of care for residents at risk for falls. The RCC said that they were the lead for the Falls Prevention and Management Program in the home starting when they started in the RCC position in early May 2019. The RCC said they were familiar with this resident and this resident was considered to be at high risk for falls. The RCC acknowledged there were specific interventions included in the resident's plan of care and said that this was not something that was an effective intervention for this resident, but it was still the expectation that it would be consistently in place. The RCC said that when they started in the role they did not think anything had been done regarding the audits identified in part b) of CO #001. The RCC said after starting in the role they had done some work on the auditing of residents' plans of care, but their main focus had been auditing post-fall assessments. The RCC said that they were looking at a master list of the residents in terms of bed

alarms, chair alarms, fall mats and slider sheets to compare what was observed to what was in the plan of care and they had started to document this audit. The RCC said that they thought one of the Personal Support Worker (PSW) had started doing work on this one shift in June 2019. The RCC said on July 15, 2019, two identified staff members had assisted them to review each resident and it was a huge undertaking. The RCC said that the documentation was not yet completed related to that audit. The RCC said that callbells that were in the plan of care for resident's related to falls prevention were not part of this audit.

Based on observations, interviews and record review the licensee has failed to ensure the plan of care set out in the plan of care for falls prevention was provided to this identified resident as specified in their plan of care. The licensee has also failed to comply with CO #001 from Inspection #2019_722630_0005 as they did not develop and fully implement an auditing process by the Compliance Due Date (CDD) May 7, 2019, to ensure that the plan of care for residents at moderate or high risk for falls were provided to the residents as specified in their plans. (630) [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 July, 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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMIE GIBBS-WARD (630), MELANIE NORTHEY (563), NATALIE MORONEY (610)
Inspection No. / No de l'inspection :	2019_722630_0016
Log No. / No de registre :	029561-18, 009395-19, 009396-19, 009397-19, 009399-19, 009400-19, 009475-19
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jul 29, 2019
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care Woodstock Nursing Home 81 Fyfe Avenue, WOODSTOCK, ON, N4S-8Y2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gay Goetz

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Caressant-Care Nursing and Retirement Homes Limited, 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

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_722630_0005, 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 must be compliant with s 6 (7) of the LTCHA.

Specifically the licensee must:

a) Ensure that the care set out in the plan of care related to grooming/hygiene and falls prevention is provided to an identified resident.

b) Ensure that the care set out in the plan of care related to mobility, transfers and falls prevention is provided to three identified residents, and any other resident in the home, as specified in their plan.

c) Ensure that as part of the Falls Prevention and Management program an auditing process is developed and fully implemented to ensure that the plan of care for residents at moderate or high risk for falls are provided to the residents as specified in their plans. This auditing process must include a regular schedule for audits. The home must maintain documentation of the audits which is to include the auditing schedule, the names of the people conducting the audit, the residents who have been audited, the results of the audit and what actions were taken in regards to the audit results.

d) As part of the Falls Committee "falls tracking" activities in the home, post-fall assessments will be reviewed to determine if, at the time of the fall, the care set out in the plan of care had been provided to the resident as specified in their plan. This review and tracking will be documented as part of the Falls Committee meeting minutes.

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 licensee has failed to comply with Compliance Order (CO) #001 from #2019_722630_0005 issued on April 16, 2019, with a compliance due date of May 31, 2019.

The licensee was ordered to ensure that they were compliant with s 6 (7) of the LTCHA.

Specifically the licensee was ordered to:

a) Ensure that the care set out in the plan of care related to mobility and falls prevention is provided to resident #002 and any other resident in the home, as specified in their plan.

b) Ensure an auditing process is developed and fully implemented to ensure that the plan of care for residents at moderate or high risk for falls are provided to the residents as specified in their plans. This auditing process must be documented including the auditing schedule, the names of the people conducting the audit, the residents who have been audited, the results of the audit and what actions were taken in regards to the audit results.

The home failed to complete steps a) and b).

A) The licensee has failed to ensure the plan of care set out in the plan of care for falls prevention and grooming and hygiene was provided to an identified resident as specified in their plan of care.

On multiple occasions during the inspection, Inspector #563 observed an identified resident without a specific device applied as per the resident's plan of care. Inspector #563 also observed that this resident appeared to not have received grooming and personal hygiene as per their plan of care.

During two of the observations identified staff members were present and acknowledged that the device had not been applied to this resident as per the

plan of care

The current electronic care plan documented that this resident was at risk of falls and required a specific device to be in place as part of their falls prevention plan of care. The care plan also documented a focus related to hygiene with a goal to "be neat, clean and odour free" which included specific interventions for this resident.

The Executive Director (ED) was shown multiple pictures taken during the inspection of the resident's grooming and hygiene as well as pictures of the specific device not in use. The ED acknowledged that care set out in the plan of care related to personal hygiene and the use of the device was not provided to this identified resident as specified in the plan. (563)

B) The licensee had failed to ensure that the care set out in the plan of care was provided to another identified resident as specified in the plan related to mobility, transfers and falls prevention.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date related to a fall for this identified resident.

The clinical record for this resident documented that the resident was considered to be at risk for falls and required specific interventions that had been initiated by staff on specific dates. The plan of care for this resident included the use of specific devices and specific interventions from staff related to transferring, mobility and falls prevention.

During an interview with an identified registered nursing staff member they said this resident was considered to be at risk for falls. This staff member said they did not think that a specific device was in place for this resident as they thought the family had opted out. The staff member said that some devices that relied on an alarm were hard for staff to hear and respond to if a resident was located in a room down the hallway.

During an interview with two other identified staff members they said this resident had a fall on a specific date. They said that they did not know if the

specific device for falls prevention had been in place at the time of the fall. One staff member said the resident had been found in a specific location alone in their room at the time of the fall.

Based on these interviews and record review, the licensee has failed to ensure that the care set out in the plan of care for this resident's fall prevention was provided to the resident as specified in the plan at the time of their fall on a specific date. (630)

C) The licensee failed to ensure that the care set out in the plan of care related to falls prevention was provided to another identified resident as specified in the plan.

The current care plan for this resident documented they were at high risk of falls and included that this resident required a specific intervention related to their callbell.

On a specific date Inspector #563 observed this identified resident did not have their callbell in place as was identified in their plan of care.

During an interview and identified staff member said that this resident could verbally communicate their needs and also used the call bell.
The licensee failed to ensure that the call bell was provided to this identified resident as specified in the plan. (563)

D) The licensee has failed to ensure that the care set out in the plan of care for bed mobility was provided to another identified resident as specified in the plan.

This inspection was completed related to a CIS report that was submitted to the MOHLTC on a specific date. A review of the CI report showed that the resident sustained a specific type of injury while in the home.

Review of the resident's care plan showed a specific intervention in place related to bed mobility. It also showed that there was a specific type of assistive bed sheet in place for this resident related to bed mobility and positioning.

On specific dates, Inspector #610 observed this resident without the specific

type of assistive bed sheet in place.

During an interview an identified staff member said that this resident should have had the specific type of assistive bed sheet in place. The staff member explained how the assistive bed sheet system worked and that it could only be used by two staff.

During an interview a RAI Coordinator said this resident required the specific type of assistive bed sheet in place with a specific type of assistance from staff for positioning. The RAI Coordinator further said that front line staff had access to the Kardex and that this resident's care plan was updated for the use of this intervention.

During an interview the ED stated it was the home's expectation that staff would be using this type of device for repositioning the resident with two staff. (610)

E) The licensee has failed to ensure the plan of care set out in the plan of care for falls prevention was provided to another identified resident as specified in their plan of care.

During an interview an identified registered nursing staff member told Inspector #630 that this resident had a history of falls related to a specific reason.

On a specific date, Inspector #630 observed that this resident did not have one of the interventions in place as specified in their plan of care for falls prevention. A staff member acknowledged that this was not in place at the time of the observation and then applied the intervention.

The written plan of care for this resident included specific interventions related to mobility and falls risk. The clinical record for this resident documented multiple falls between specific dates. The documentation of the post-fall assessments demonstrated that during some of the falls the interventions were not in place as per the plan of care.

During an interview a Resident Assessment Instrument (RAI) Coordinator said they were familiar with Compliance Order (CO) #001 from #2019_722630_0005 related to the plan of care for residents at risk for falls. The RAI Coordinator said

they were familiar with this resident and they were considered to be at high risk for falls and continued to fall related to specific reasons. The RAI Coordinator and Inspector #630 reviewed the post fall assessment for this resident for a specific date, and the RAI Coordinator said that the assessment suggested care had not been provided as per the plan of care at the time of this fall. The RAI Coordinator said that they were involved in helping to develop the plan of care for residents at risk for falls, but had not personally involved in completing audits to ensure the care was provided to the residents.

During an interview a Resident Care Coordinator (RCC) said they were familiar with Compliance Order (CO) #001 from #2019_722630_0005 related to the plan of care for residents at risk for falls. The RCC said that they were the lead for the Falls Prevention and Management Program in the home starting when they started in the RCC position in early May 2019. The RCC said they were familiar with this resident and this resident was considered to be at high risk for falls. The RCC acknowledged there were specific interventions included in the resident's plan of care and said that this was not something that was an effective intervention for this resident, but it was still the expectation that it would be consistently in place. The RCC said that when they started in the role they did not think anything had been done regarding the audits identified in part b) of CO #001. The RCC said after starting in the role they had done some work on the auditing of residents' plans of care, but their main focus had been auditing post-fall assessments. The RCC said that they were looking at a master list of the residents in terms of bed alarms, chair alarms, fall mats and slider sheets to compare what was observed to what was in the plan of care and they had started to document this audit. The RCC said that they thought one of the Personal Support Worker (PSW) had started doing work on this one shift in June 2019. The RCC said on July 15, 2019, two identified staff members had assisted them to review each resident and it was a huge undertaking. The RCC said that the documentation was not yet completed related to that audit. The RCC said that callbells that were in the plan of care for resident's related to falls prevention were not part of this audit.

Based on observations, interviews and record review the licensee has failed to ensure the plan of care set out in the plan of care for falls prevention was provided to this identified resident as specified in their plan of care. The licensee has also failed to comply with CO #001 from Inspection

#2019_722630_0005 as they did not develop and fully implement an auditing process by the Compliance Due Date (CDD) May 7, 2019, to ensure that the plan of care for residents at moderate or high risk for falls were provided to the residents as specified in their plans. (630) [s. 6. (7)]

The severity of this issue was determined to be a level three as there was potential for actual risk. The scope of the issue was a level two as it related to a pattern. The home had a level 4 history as they had multiple non compliances with at least one related re-issued order to this sub-section of the legislation that included:

- Written Notification (WN) and Compliance Order (CO) issued April 16, 2019 (2019_722630_0005) with compliance due date May 7, 2019;
- WN and CO issued October 23, 2018 (2018_722630_0019) with compliance due date December 31, 2018;
- WN and Voluntary Plan of Correction (VPC) issued January 17, 2018 (2018_606563_0001);
- WN and VPC issued August 24, 2017 (2017_605213_0017);
- WN and VPC issued June 29, 2017 (2017_605213_0007);
- WN and Compliance Order (CO) issued January 25, 2017 (2016_303563_0042). The CO was complied May 23, 2017 (2017_605213_0007);
- WN and VPC issued October 20, 2016 (2016_326569_0021).

Note: A Director's Referral (DR) was not issued at this time for this non-compliance as the home already has a DR in process from Inspection #2019_722630_0005. (630)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 31, 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 29th day of July, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amie Gibbs-Ward

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