Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 09, 2020	2020_722630_0001 (A1)	008897-19, 015089-19, 015090-19, 015091-19, 020293-19	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

Amended by AMIE GIBBS-WARD (630) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The home requested an extension to the compliance due date (CDD) of April 30, 2020, for CO #001 from inspection 2020_722630_0001 related to O. Reg 79/10, s 8. (1). Based on a review by Inspector #630, Inspection Manager and Service Area Office Manager this request was granted on April 9, 2020, and the CDD has been extended to June 15, 2020.

Issued on this 9 th day of April, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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81 Fyfe Avenue WOODSTOCK ON N4S 8Y2

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

Amended by AMIE GIBBS-WARD (630) - (A1)

Amended 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): January 6, 7, 8, 9, 10, 13 and 14, 2020.

The following Follow-up intakes were completed within this inspection:

Log #020293-19 for Compliance Order (CO) #001 from inspection #2019_778563_0033 related to medication administration;

Log #008897-19 for CO#002 from inspection #2019_722630_0006 related to responsive behaviours and the responsive behaviours program;

Log #015089-19 for CO #001 from inspection #2019_722630_0017 (A1) related to the plan of care for Oxygen Therapy;

Log #015090-19 for CO #002 from inspection #2019_722630_0017 (A1) related to the home's Oxygen Therapy policy;

Log #015091-19 for CO#003 from inspection #2019_722630_0017 related to the home's Falls Management Policy and procedures.

Documentation of non-compliance related to Critical Incident Inspection #2020_722630_0003 for Log 023769-19 and Log #023531-19 as well as Complaint Inspection #2020_722630_0002 for Log #023894-19 have been documented within this Follow-Up Inspection Report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Assistant ED, OMNI Lead, the OMNI Clinical Operations Manager, the Director of Care (DOC), the Assistant Director of Care (ADOC), Resident Care Coordinators (RCC), a Physiotherapist (PT), the Behavioural Supports Ontario (BSO) Registered Practical Nurse (RPN), Registered Nurses (RNs), RPNs, Personal Support Workers (PSWs), family members and residents.

The inspectors also observed resident rooms and common areas, 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 recommendations provided to the home by OMNI and also reviewed the Caressant Care Woodstock Compliance Plan of Corrective Action.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Personal Support Services
Responsive Behaviours

During the course of the original 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. 131. (2)	CO #001	2019_778563_0033	563
O.Reg 79/10 s. 53. (4)	CO #002	2019_722630_0006	730
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2019_722630_0017	630
O.Reg 79/10 s. 8. (1)	CO #002	2019_722630_0017	630

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place

any policy and procedure, the policy and procedure was in compliance with and implemented in accordance with all applicable requirements under the Act and was complied with.

In accordance with the requirements under O. Reg. 79/10 s. 30 (1) as well as in accordance with the requirement under O. Reg. 79/10 s. 48 (1) the licensee has failed to ensure that the policy that was in place for the required Falls Prevention and Management program to reduce the incidence of falls and the risk of injury met the requirements and that the staff in the home complied with the policy and procedures in place.

The licensee has failed to comply with Compliance Order (CO) #003 from #2019_722630_0017 issued on July 29, 2019, with a compliance due date of October 31, 2019.

The licensee was ordered to ensure that they were compliant with O. Reg. 79/10, s 8. (1).

Specifically the licensee was ordered to:
a) Ensure that staff in the home respond to each resident's fall in accordance with the home's falls prevention and management policies and procedures.
b) Ensure that after three specific residents, or any other resident has fallen their falls prevention interventions are reviewed and revised as part of the post-fall assessment, in accordance with the home's falls prevention and management policies and procedures.
c) As part of the Falls Committee "falls tracking" activities in the home, post-fall assessments will be reviewed to determine if the staff complied with the home's falls prevention and management policies related to their response to the fall and the review of the resident's plan of care for falls prevention interventions. This review and tracking will be documented as part of the Falls Committee meeting minutes.

The home completed step c).

During the inspection the Executive Director (ED) provided the home’s current policies and procedures for falls prevention and management. The ED said the home had implemented a revised policy. The title of the policy was “Management of resident falls, restraints, post fall management” with effective date July 2019.

The staff in the home failed to comply with specific sections of the home's policy and procedures titled "Management of resident falls, restraints, post fall management" with effective date July 2019. This included procedures that were in "Part A – Resident Falls Risk" as well as procedures in "Part B – Post Fall Management Upon discovery of a fall."

A) The three identified residents in CO #003 were still present in the home at the time of the inspection.

Based on a review of the clinical records for these three identified residents they had each sustained one or more falls between November 1, 2019 and January 10, 2020. The review found that the post-fall assessments had not been consistently completed as per the home's policies and procedures. A review of the plan of care for two of these residents found the interventions had not been updated when they were not effective.

During an interview a Resident Care Coordinator (RCC) said they started in the home in December 2019 and they were the new lead for the Falls Prevention and Management program. The RCC said they were familiar with the compliance order and the home's policy for falls prevention and management. The RCC said staff were expected to complete post fall assessments in accordance with the policy which included the completion of a Head Injury Routine (HIR) assessment form for unwitnessed fall or falls with a head injury. The RCC acknowledged that based on the documentation the assessments had not been consistently completed as per the home's policies and procedures for these residents.

During an interview the Assistant Director of Care (ADOC) said they had been leading the falls prevention and management program temporarily in October and November 2019. They said they were familiar with the current policy. They acknowledged it did not include a definition of fall and they thought a fall was considered if the resident moved from one position to another without purpose of doing so. When asked how staff would know what was considered a fall in the home, the ADOC said that they may not know as it was not in the policy. When asked if the current policy provided direction for PSW staff on what they are to do if they discovered that a resident had fallen or if a resident was on the floor, the ADOC said this was not included in the current policy. (630)

B) The home submitted A Critical Incident System (CIS) report to the Ministry of Long-Term Care (MOLTC) for a fall for an identified resident in December 2019.

This report stated the resident had sustained multiple falls in the past quarter.

Based on a review of the clinical records for this identified resident they had sustained multiple falls between November 1, 2019 and December 2019. The review found that the post-fall assessments had not been consistently completed as per the home's policies and procedures. A review of the plan of care found the interventions had not been updated when they were not effective.

During interviews with specific staff members they reported this resident had experienced multiple falls. The staff expressed concerns related to assessments that were completed and actions taken related to a specific fall.

During an interview the ADOC said they were familiar with this specific resident. The ADOC said that they were involved in investigating the fall reported in the CIS and during that investigation they were not able to determine who had discovered that resident had fallen. The ADOC acknowledged the plan of care for this resident had not been updated until after the fall reported in the CIS. The ADOC also acknowledged the documented post fall assessment did not include all of the required information. (630)

C) The MOLTC received another CIS report in December 2019, related to an alleged incident between two residents. The CIS report documented that there had been a potential fall.

Based on a review of the clinical record the progress notes documented that the resident was on the floor. The clinical record did not include a completed post fall assessment for this resident.

During an interview with a staff member they said this resident had been found on the floor.

During an interview with the ADOC they acknowledged that when registered staff did not complete a Post- Falls Assessment for this incident. (730)

D) The MOLTC received an anonymous complaint related to the home's falls prevention and management program. The anonymous complainant indicated concerns related to the response and assessments by staff in the home for a specific resident's fall. The complainant reported they felt the resident had not received the care they thought they required after the fall.

A review of the home's "Management of resident falls, restraints, post fall management" with effective date July 2019, by Inspector #630 identified that the policy provided direction for "registered staff" regarding the procedures for responding to a fall but did not include direction for other members of the interdisciplinary team including Personal Support Worker (PSW) staff.

In separate interviews three Personal Support Workers (PSWs) said if a resident had fallen they thought their role was to not move the resident and to alert the registered staff. They said they would know what to do if a resident had fallen based on several years of past practices in the home.

During an interview the OMNI Registered Nurse (RN) Clinical Operations Manager said they were involved in supporting the home with revising the home's policy on falls prevention and management. They said the PSW staff in the home were expected to ensure residents were safe and to contact registered nursing staff if a resident had fallen. They acknowledged that the home's revised policy did not provide direction for PSW staff in the home on how to respond if a resident had fallen. The OMNI RN Clinical Operations Manager said the home used the Canadian Institute for Health Information (CIHI) definition of a fall and considered a fall to be any time a resident changed position from their normal position. They acknowledged that the current policy did not make reference to this definition of fall for the staff in the home.

Based on these interviews and record review the licensee has failed to comply with CO #003 from Inspection #2019_722630_0017 with compliance due date of October 31, 2019. The licensee has failed to ensure that the policy and procedures in place for the Falls Prevention and Management program were implemented in accordance with all applicable requirements under the Act and were complied with. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

Issued on this 9 th day of April, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by AMIE GIBBS-WARD (630) - (A1)
Inspection No. / No de l'inspection :	2020_722630_0001 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	008897-19, 015089-19, 015090-19, 015091-19, 020293-19 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Apr 09, 2020(A1)
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 :	Carol Bradley

Ontario

Ministry of Long-Term Care

Ministère 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 Long-Term Care

Ministère 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

Order # / No d'ordre: 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_722630_0017, CO #003;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 8. (1).

Specifically the licensee must:
a) Review and revise the home's Fall Prevention and Management program policies and procedures to ensure they provide clear home-specific directions for the interdisciplinary team in order to reduce the incidence of falls and the risk of injury. This review must:
i) ensure the policy and procedures provides clear direction to Personal Support Worker (PSW) staff, registered nursing staff and any interdisciplinary staff working in the home on how to respond if a resident has fallen;
ii) ensure the policy and procedures provides clear direction, based on best practice guidelines, regarding what is considered to be a resident fall;
iii) include at least one Personal Support Worker (PSW), one Registered Practical Nurse (RPN) and one Registered Nurse (RN), the Physiotherapist (PT) for the home and the Falls Prevention and Management Program lead working in the home;
iv) include a documented record of the review and revisions made, including the name of staff involved and the date they were involved.

b) Ensure all staff working in the home, including agency staff, are trained on the components of the revised Falls Prevention and Management policies and procedures which applies to their position. The home must keep a documented record of the education including: a summary and percentage of the staff who completed the education by the compliance due date and the materials covered in the education for each group of staff.

c) Ensure the revised falls Prevention and Management policies and procedures are fully implemented for four specific residents, and any other resident in the home who is at risk for falls.

d) Ensure the interdisciplinary team completes a documented review of the falls related progress notes, post fall assessments and the plan of care for resident two specific residents to determine the effectiveness of their interventions for falls prevention and management. Based on this review, documented revisions to the plan of care for these residents will be implemented.

e) Ensure the interdisciplinary Falls Prevention and Management committee activities in the home includes monthly audits of the staff's compliance with the home's Falls Prevention and Management policies. The home must keep a documented record of the monthly audits including: the name and position of the people completing the audits; when the audits were completed; which residents were audited; the components of the policy and procedures which were audited; and the actions taken related to the results of the audits.

Grounds / Motifs :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy and procedure, the policy and procedure was in compliance with and implemented in accordance with all applicable requirements under the Act and was complied with.

In accordance with the requirements under O. Reg. 79/10 s. 30 (1) as well as in accordance with the requirement under O. Reg. 79/10 s. 48 (1) the licensee has failed to ensure that the policy that was in place for the required Falls Prevention and Management program to reduce the incidence of falls and the risk of injury met the

requirements and that the staff in the home complied with the policy and procedures in place.

The licensee has failed to comply with Compliance Order (CO) #003 from #2019_722630_0017 issued on July 29, 2019, with a compliance due date of October 31, 2019.

The licensee was ordered to ensure that they were compliant with O. Reg. 79/10, s 8. (1).

Specifically the licensee was ordered to:
a) Ensure that staff in the home respond to each resident's fall in accordance with the home's falls prevention and management policies and procedures.
b) Ensure that after three specific residents, or any other resident has fallen their falls prevention interventions are reviewed and revised as part of the post-fall assessment, in accordance with the home's falls prevention and management policies and procedures.
c) As part of the Falls Committee "falls tracking" activities in the home, post-fall assessments will be reviewed to determine if the staff complied with the home's falls prevention and management policies related to their response to the fall and the review of the resident's plan of care for falls prevention interventions. This review and tracking will be documented as part of the Falls Committee meeting minutes.

The home completed step c).

During the inspection the Executive Director (ED) provided the home's current policies and procedures for falls prevention and management. The ED said the home had implemented a revised policy. The title of the policy was "Management of resident falls, restraints, post fall management" with effective date July 2019.

The staff in the home failed to comply with specific sections of the home's policy and procedures titled "Management of resident falls, restraints, post fall management" with effective date July 2019. This included procedures that were in "Part A – Resident Falls Risk" as well as procedures in "Part B – Post Fall Management Upon discovery of a fall."

A) The three identified residents in CO #003 were still present in the home at the

time of the inspection.

Based on a review of the clinical records for these three identified residents they had each sustained one or more falls between November 1, 2019 and January 10, 2020. The review found that the post-fall assessments had not been consistently completed as per the home's policies and procedures. A review of the plan of care for two of these residents found the interventions had not been updated when they were not effective.

During an interview a Resident Care Coordinator (RCC) said they started in the home in December 2019 and they were the new lead for the Falls Prevention and Management program. The RCC said they were familiar with the compliance order and the home's policy for falls prevention and management. The RCC said staff were expected to complete post fall assessments in accordance with the policy which included the completion of a Head Injury Routine (HIR) assessment form for unwitnessed fall or falls with a head injury. The RCC acknowledged that based on the documentation the assessments had not been consistently completed as per the home's policies and procedures for these residents.

During an interview the Assistant Director of Care (ADOC) said they had been leading the falls prevention and management program temporarily in October and November 2019. They said they were familiar with the current policy. They acknowledged it did not include a definition of fall and they thought a fall was considered if the resident moved from one position to another without purpose of doing so. When asked how staff would know what was considered a fall in the home, the ADOC said that they may not know as it was not in the policy. When asked if the current policy provided direction for PSW staff on what they are to do if they discovered that a resident had fallen or if a resident was on the floor, the ADOC said this was not included in the current policy. (630)

B) The home submitted A Critical Incident System (CIS) report to the Ministry of Long-Term Care (MOLTC) for a fall for an identified resident in December 2019. This report stated the resident had sustained multiple falls in the past quarter.

Based on a review of the clinical records for this identified resident they had sustained multiple falls between November 1, 2019 and December 2019. The review found that the post-fall assessments had not been consistently completed as per the

home's policies and procedures. A review of the plan of care found the interventions had not been updated when they were not effective.

During interviews with specific staff members they reported this resident had experienced multiple falls. The staff expressed concerns related to assessments that were completed and actions taken related to a specific fall.

During an interview the ADOC said they were familiar with this specific resident. The ADOC said that they were involved in investigating the fall reported in the CIS and during that investigation they were not able to determine who had discovered that resident had fallen. The ADOC acknowledged the plan of care for this resident had not been updated until after the fall reported in the CIS. The ADOC also acknowledged the documented post fall assessment did not include all of the required information. (630)

C) The MOLTC received another CIS report in December 2019, related to an alleged incident between two residents. The CIS report documented that there had been a potential fall.

Based on a review of the clinical record the progress notes documented that the resident was on the floor. The clinical record did not include a completed post fall assessment for this resident.

During an interview with a staff member they said this resident had been found on the floor.

During an interview with the ADOC they acknowledged that when registered staff did not complete a Post- Falls Assessment for this incident. (730)

D) The MOLTC received an anonymous complaint related to the home's falls prevention and management program. The anonymous complainant indicated concerns related to the response and assessments by staff in the home for a specific resident's fall. The complainant reported they felt the resident had not received the care they thought they required after the fall.

A review of the home's "Management of resident falls, restraints, post fall management" with effective date July 2019, by Inspector #630 identified that the

policy provided direction for "registered staff" regarding the procedures for responding to a fall but did not include direction for other members of the interdisciplinary team including Personal Support Worker (PSW) staff.

In separate interviews three Personal Support Workers (PSWs) said if a resident had fallen they thought their role was to not move the resident and to alert the registered staff. They said they would know what to do if a resident had fallen based on several years of past practices in the home.

During an interview the OMNI Registered Nurse (RN) Clinical Operations Manager said they were involved in supporting the home with revising the home's policy on falls prevention and management. They said the PSW staff in the home were expected to ensure residents were safe and to contact registered nursing staff if a resident had fallen. They acknowledged that the home's revised policy did not provide direction for PSW staff in the home on how to respond if a resident had fallen. The OMNI RN Clinical Operations Manager said the home used the Canadian Institute for Health Information (CIHI) definition of a fall and considered a fall to be any time a resident changed position from their normal position. They acknowledged that the current policy did not make reference to this definition of fall for the staff in the home.

Based on these interviews and record review the licensee has failed to comply with CO #003 from Inspection #2019_722630_0017 with compliance due date of October 31, 2019. The licensee has failed to ensure that the policy and procedures in place for the Falls Prevention and Management program were implemented in accordance with all applicable requirements under the Act and were complied with. [s. 8. (1) (a),s. 8. (1) (b)]

The severity of this issue was determined to be a level two as there was minimal harm. The scope of the issue was a level three as it was widespread. The home had a level 5 history as a CO is being re-issued related to the same sub-section and the home had 4 or more previous COs for the same sub-section of the legislation that included:
- Written Notification (WN) and Compliance Order (CO) issued July 29, 2019 (2019_722630_0017)
with compliance due date October 31, 2019.
- WN and CO issued July 29, 2019 (2019_722630_0017(A1)) with compliance due

date November 30, 2019. The CO was complied January 2020.
- WN and CO issued May 7, 2019 (2019_778563_0013) with compliance due date May 31, 2019. The CO was complied July 2019.
- WN and CO issued February 19, 2019 (2019_778563_0006) with compliance due date March 31,
2019 which was closed with link May 7, 2019;
- WN and CO issued October 23, 2018 (2018_722630_0019) with compliance due date June 30,
2019. The CO was complied July 2019;
- WN and CO issued July 16, 2018 (2018_508137_0017) with compliance due date July 31, 2018
which was closed with link October 23, 2019;
- WN and Voluntary Plan of Correction (VPC) issued January 17, 2018 (2018_606563_0001);
- WN, CO and Director's Referral (DR) issued August 24, 2017 (2017_605213_0015) with
compliance due date September 8, 2017. This CO was complied October 5, 2017;
- WN and CO issued May 24, 2017 (2016_229213_0039) with compliance due date June 30, 2017
which was closed with link August 23, 2017. (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 15, 2020(A1)

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

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 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:

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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 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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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 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 9 th day of April, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by AMIE GIBBS-WARD (630) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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