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
Oct 17, 2019	2019_722630_0028	011894-19, 011999-19, 012749-19, 013345-19, 016925-19, 019324-19	Critical Incident System

Licensee/Titulaire de permis

Copper Terrace Limited
284 Central Avenue LONDON ON N6B 2C8

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

Copper Terrace
91 Tecumseh Road CHATHAM ON N7M 1B3

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

AMIE GIBBS-WARD (630), CHRISTINA LEGOUFFE (730), JULIE DALESSANDRO (739), MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 26, 27 and 30, October 1, 2, 3, 4, 7, 8 and 9, 2019.

The following Critical Incident System (CIS) intakes were completed within this inspection:

Related to the prevention of abuse and neglect:
Log #013345-19 / CI 1115-000038-19
Log #016925-19 / CI 1115-000042-19

Related to medication administration:
Log #011894-19 / CI 1115-000030-19

Related to Safe and Secure Homes and Maintenance Services:
Log #011999-19 / CI 1115-000031-19
Log #012749-19 / CI 1115-000034-19
Log #019324-19 / CI 1115-000054-19

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the APANS Director Special Projects, the APANS Nurse Consultant, the Director of Clinical Services (DOCS), the Associate DOCS Second Floor, the Associate DOCS Third Floor, the Director of Culinary Services, the Director of Environmental Services, the Resident Assessment Instrument (RAI) Coordinator, the Behavioural Supports Ontario (BSO) Registered Practical Nurse (RPN), Registered Nurses (RNs), RPNs, Personal Support Workers (PSWs), a Housekeeper, a Dietary Aide, family members and residents.

The inspectors also observed resident rooms and common areas, observed medication storage areas, observed medication administration, observed meal and 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 the written staffing plan of the home for RNs, RPNs and PSWs, reviewed various meeting minutes and reviewed written records of program evaluations.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

4 WN(s)
1 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to, were equipped with an audible door alarm and were also connected to the resident-staff communication and response system or connected to an audio visual enunciator that was connected to the nurses' station nearest to the door and had a

manual reset switch at each door.

A) On October 4, 2019, Inspector #630 arrived at the home and the front entrance door was closed but unlocked and no audible alarm was observed. Inspector #630 then asked the Executive Director (ED) and Director of Environmental Services (DES) about the expectations in the home regarding the front door and they stated that the door lock was on a delay to allow residents and other visitors time to enter and exit the home.

On October 4, 2019, Inspector #739 observed the main door and noticed that the main entry door was open for a total of two minutes and 36 seconds without an audible alarm sounding at the point of activation on the main floor.

During an interview with a staff member they stated that the main entry door alarm was audible on Two North when the door was open for too long. They stated that on the resident-staff communication and response system screen it would read "Main Entry" and the staff would then page "main entry" and then it would take approximately five minutes for the alarm to be shut off. They stated that there was not an audible alarm on the main floor where the door was located.

During an interview with another staff member, it was observed by Inspector #739 that "main entry" had been paged three times. The response system screen in the Two North nurses station showed that it had alarmed for six minutes and 31 seconds before being turned off at the point of activation which was the main entrance. The staff member stated that they had no way of knowing what was happening at the main door, if it was opened or closed or if residents were leaving.

Record review of Main Entry door alarm audit from September 23 to October 6, 2019, indicated that there were fourteen separate occasions that the main entry door alarm was activated through the resident-staff communication and response system. For example, on September 28, 2019 at 1843 hours, the main entry door alarm sounded for five minutes and 21 seconds; on September 29, 2019 at 1232 hours, the main entry door alarm sounded for 11 minutes and 34 seconds; and on October 1, 2019 at 1606 hours, the main entry door alarm sounded for 13 minutes and 20 seconds before being turned off at the point of activation.

B) On October 4, 2019, Inspector #739 also identified that the doors leading to the stairwells in the home were not equipped with an audible alarm and determined that further observations were required.

On October 4, 2019, Inspectors #563, #630, and #739 conducted observations of the doors leading to stairwells in the home and found that the following doors were not equipped with an audible alarm nor were they connected to the resident-staff communication and response system: One South; both doors on Two North; both doors on Three North; the door closest to the elevator Two East; and the door closest to the elevator on Three East. For example, Inspector #739 observed that the stairwell door at the far end of the hall on Two North had been open for three minutes and 50 seconds without an audible alarm to alert staff that the door was open.

During an interview with a staff member working on Two North they stated that they would not know if the stairwell door on their floor was opened or remained open as there was no audible alarm to indicate that the door was open and there was no indication on the resident-staff communication and response system.

C) On October 4, 2019, the ED stated that the door alarm for the main door was only audible on the second floor, Two North, and not anywhere else in the home. They stated that the staff on Two North were to page "main entrance" and then whoever got there first was responsible for deactivating the alarm. The ED stated that the home installed a new magnetic lock for the front door approximately two weeks prior and the alarm had not sounded on the main floor since that installation.

On October 4, 2019, the home submitted a Critical Incident (CI) report to the Ministry of Long-Term Care (MOLTC). The CI report stated that it was identified by the MOLTC Inspectors that the key pads for the magnetic locks on the stairwell doors on the North wing and at the main entrance were not audible. The report stated the main door entrance key pad was replaced approximately two weeks prior and was not programmed for an audible alarm at the door, it was only audible at the nurse station on Two North. The report also stated that the Director of Environmental Services (DES) audited all the doors and found ten that would require audible alarms.

On October 7, 2019, during a follow-up interview the ED and stated that the electrical company had been in over the weekend and had placed an alarm on the front door leading to the outside. The DES said that the new audible alarm stopped once the door closed and therefore did not require someone to cancel the alarm at the point of activation. The ED said they recognized that the work that was done on the front door alarm did not meet the requirements of the Long-Term Care Homes Act and Regulations. The ED also acknowledged that there were doors leading to stairwells in the home that

not were connected to an audible alarm or to the resident-staff communication and response system. [s. 9. (1)] (739)

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

The home submitted a Critical Incident (CI) System report which documented that an identified resident had been administered a medication on a specific date and this medication was not prescribed for the resident at the time as it had been discontinued.

The Physician Orders in Point Click Care (PCC) documented that this medication had been ordered for the resident on a specific date and discontinued on a different specific date.

The Best Possible Medication Reconciliation History (BPMH) for a specific date was signed and stated that this medication was to be discontinued.

There was a Hogan Pharmacy Partners Ltd. Medication Incident report created on a specific date and documented that the resident had been given a medication that had been discontinued.

The Hogan Pharmacy Partners Ltd. Medication Orders - Medication Reconciliation on Admission, Readmission, Transfer and Discharge (also known as Med Rec) Policy stated "The goal of medication reconciliation is to create a best possible medication history (BPMH) and detect and resolve all discrepancies to reduce the risk of adverse medication incidents."

During an interview a staff member stated there was a medication incident involving an identified resident. The staff member stated they thought the orders were verified from pharmacy and had administered the medication to the resident and then realized it had been discontinued.

During an interview the Director of Clinical Services (DOCS) stated they were aware of the medication incident. The DOCS said the resident had been administered the medication without a prescription as it had previously been discontinued.

The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident as a specific medication was given to an identified resident after it had been discontinued. [s. 131. (1)] (563)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MOLTC) related to an alleged incident of resident to resident abuse.

The home's policy with subject line "Abuse- Prevention, Elimination & Reporting Policy" and an effective date of September 2019, stated under the heading "Mandatory Reporting to the Home's Management" that all suspected, alleged or witnessed incidents of abuse or neglect causing harm or risk to a resident must be immediately reported to management.

During separate interviews with three staff members each one stated that the expectation in the home was that an allegation of abuse would be reported immediately to management.

During an interview with a staff member they said that they had been working when the incident happened between these two residents and said that they could not recall if they had notified the manager on-call immediately regarding the incident.

During an interview with an Associate Director of Clinical Services (ADOCS) they said that it was their expectation that the after- hours line for the MOLTC care would have been called on the night that the incident occurred between these two residents, but in this case it was not. The said that the manager on-call was not immediately made aware of the incident by staff but instead was made aware the following day.

The licensee has failed to ensure that the licensee's written policy to promote zero tolerance of abuse and neglect complied with regarding immediate reporting to the manager on-call for the alleged resident to resident abuse. [s. 20. (1)] (730)

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident fell, a post- fall assessment using a clinically appropriate assessment that was specifically designed for falls, was conducted.

The home submitted a Critical Incident System (CIS) report to the MOLTC related to an alleged incident of resident to resident abuse which stated that an identified resident fell during the incident.

Review of the home's policy with subject "Fall Prevention Program- Post Fall Management Policy," with an effective date of May 2018, stated that registered staff were to initiate a "Fall with Injury" or "Fall without Injury" incident in Point Click Care (PCC) Risk Management when a resident sustained a fall.

Review of the progress notes for one of the identified resident showed a note which documented that the resident had fallen.

During an interview with a staff member they said that the expectation in the home was that after a resident fell, a post-fall assessment would be completed in PCC Risk Management by registered staff.

Inspector #730 and a staff member reviewed the Risk Management section in PCC and there was no post-falls assessment for this resident's fall. The staff member said that they had not completed a post- falls assessment when the resident fell. The staff member said they should have also completed a post-fall assessment.

During an interview with an ADOCS they said no post-fall assessment was competed when the resident fell. They said that they expected that a post-falls assessment would have been completed.

The licensee has failed to ensure that when an identified resident fell on a specific date, a post-falls assessment was completed using a clinically appropriate assessment that was specifically designed for falls. [s. 49. (2)] (730)

Issued on this 18th day of October, 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), CHRISTINA LEGOUFFE (730), JULIE DALESSANDRO (739), MELANIE NORTHEY (563)
Inspection No. / No de l'inspection :	2019_722630_0028
Log No. / No de registre :	011894-19, 011999-19, 012749-19, 013345-19, 016925-19, 019324-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 17, 2019
Licensee / Titulaire de permis :	Copper Terrace Limited 284 Central Avenue, LONDON, ON, N6B-2C8
LTC Home / Foyer de SLD :	Copper Terrace 91 Tecumseh Road, CHATHAM, ON, N7M-1B3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Donna Mcleod

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 Copper Terrace 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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10 s. 9 (1).

Specifically, the licensee must ensure that:

a) All doors leading to stairways are equipped with an audible door alarm that allows calls to be cancelled only at the point of activation.

b) All doors leading to stairways are either connected to the resident-staff communication and response system or connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

c) All doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces or doors that residents do not have access to, are equipped with an audible door alarm that allows calls to be cancelled only at the point of activation.

d) An auditing process is developed, implemented and documented in the home to ensure that the rules regarding doors in the home, as stated in O. Reg. 79/10 s. 9. (1) 1., are complied with. A written record must be kept in the home of the audits including who completed each audit, when each audit was completed, the results of the audits and the corrective actions taken.

Grounds / Motifs :

1. The licensee has failed to ensure that all doors leading to stairways and doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to, were equipped with an audible door alarm and were also connected to the resident-staff communication and response system or connected to an audio visual enunciator that was connected to the nurses' station nearest to the door and had a manual reset switch at each door.

A) On October 4, 2019, Inspector #630 arrived at the home and the front entrance door was closed but unlocked and no audible alarm was observed. Inspector #630 then asked the Executive Director (ED) and Director of Environmental Services (DES) about the expectations in the home regarding the

front door and they stated that the door lock was on a delay to allow residents and other visitors time to enter and exit the home.

On October 4, 2019, Inspector #739 observed the main door and noticed that the main entry door was open for a total of two minutes and 36 seconds without an audible alarm sounding at the point of activation on the main floor.

During an interview with a staff member they stated that the main entry door alarm was audible on Two North when the door was open for too long. They stated that on the resident-staff communication and response system screen it would read "Main Entry" and the staff would then page "main entry" and then it would take approximately five minutes for the alarm to be shut off. They stated that there was not an audible alarm on the main floor where the door was located.

During an interview with another staff member, it was observed by Inspector #739 that "main entry" had been paged three times. The response system screen in the Two North nurses station showed that it had alarmed for six minutes and 31 seconds before being turned off at the point of activation which was the main entrance. The staff member stated that they had no way of knowing what was happening at the main door, if it was opened or closed or if residents were leaving.

Record review of Main Entry door alarm audit from September 23 to October 6, 2019, indicated that there were fourteen separate occasions that the main entry door alarm was activated through the resident-staff communication and response system. For example, on September 28, 2019 at 1843 hours, the main entry door alarm sounded for five minutes and 21 seconds; on September 29, 2019 at 1232 hours, the main entry door alarm sounded for 11 minutes and 34 seconds; and on October 1, 2019 at 1606 hours, the main entry door alarm sounded for 13 minutes and 20 seconds before being turned off at the point of activation.

B) On October 4, 2019, Inspector #739 also identified that the doors leading to the stairwells in the home were not equipped with an audible alarm and determined that further observations were required.

On October 4, 2019, Inspectors #563, #630, and #739 conducted observations of the doors leading to stairwells in the home and found that the following doors were not equipped with an audible alarm nor were they connected to the resident-staff communication and response system: One South; both doors on Two North; both doors on Three North; the door closest to the elevator Two East; and the door closest to the elevator on Three East. For example, Inspector #739 observed that the stairwell door at the far end of the hall on Two North had been open for three minutes and 50 seconds without an audible alarm to alert staff that the door was open.

During an interview with a staff member working on Two North they stated that they would not know if the stairwell door on their floor was opened or remained open as there was no audible alarm to indicate that the door was open and there was no indication on the resident-staff communication and response system.

C) On October 4, 2019, the ED stated that the door alarm for the main door was only audible on the second floor, Two North, and not anywhere else in the home. They stated that the staff on Two North were to page "main entrance" and then whoever got there first was responsible for deactivating the alarm. The ED stated that the home installed a new magnetic lock for the front door approximately two weeks prior and the alarm had not sounded on the main floor since that installation.

On October 4, 2019, the home submitted a Critical Incident (CI) report to the Ministry of Long-Term Care (MOLTC). The CI report stated that it was identified by the MOLTC Inspectors that the key pads for the magnetic locks on the stairwell doors on the North wing and at the main entrance were not audible. The report stated the main door entrance key pad was replaced approximately two weeks prior and was not programmed for an audible alarm at the door, it was only audible at the nurse station on Two North. The report also stated that the Director of Environmental Services (DES) audited all the doors and found ten that would require audible alarms.

On October 7, 2019, during a follow-up interview the ED and stated that the electrical company had been in over the weekend and had placed an alarm on the front door leading to the outside. The DES said that the new audible alarm stopped once the door closed and therefore did not require someone to cancel

the alarm at the point of activation. The ED said they recognized that the work that was done on the front door alarm did not meet the requirements of the Long-Term Care Homes Act and Regulations. The ED also acknowledged that there were doors leading to stairwells in the home that not were connected to an audible alarm or to the resident-staff communication and response system. [s. 9. (1)]

The severity of this issue was determined to be level two as there was potential for harm. The scope of this issue was level three as it was widespread as it was observed in 10 of 12 doors inspected. The home had a level three history as they had previous non-compliance with the same subsection of O. Reg 79/10 that included:
- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued November 2, 2018 (2018_607523_0026). (739)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 19, 2020

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 17th day of October, 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