Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 8, 2019	2019_777731_0006	030230-18, 030270-18, 003585-19	Complaint

Licensee/Titulaire de permis

Meritas Care Corporation
567 Victoria Avenue WINDSOR ON N9A 4N1

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

Franklin Gardens Long Term Care Home
24 Franklin Road LEAMINGTON ON N8H 4B7

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

KRISTEN MURRAY (731), AMBERLY COWPERTHWAITE (435)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 25, 26, 27, and 28, 2019

The following Complaint intakes were completed within this inspection:

Complaint Log #003585-19 / IL-64249-LO related to hospitalization and change in condition, and infection prevention and control.

Complaint Log #030230-18 / IL-61759-LO related to the prevention of abuse and neglect.

The following Critical Incident System intake related to the same issue (the prevention of abuse and neglect) was inspected during this Complaint inspection:

Critical Incident Log #030270-18 / CI 2602-000040-18

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members, and residents.

The inspectors also observed residents and the care provided to them, resident rooms and common areas, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed staff schedules, and reviewed the home's documentation related to specific complaints.

Inspectors Helene Desabrais (#615) and Meagan McGregor (#721) were also present during this inspection.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation

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

2 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff.

Ontario Regulation 79/10 s.2 (1) defines “emotional abuse” as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident".

Ontario Regulation 79/10 s.2 (1) defines “verbal abuse” as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth that is made by anyone other than a resident".

The Ministry of Health and Long-Term Care (MOHLTC) received an anonymous complaint via the MOHLTC Info-Line outlining concerns for an identified resident’s safety in the home related to a specific staff member. The complainant alleged an incident of staff to resident abuse to the identified resident by the specified staff member.

The MOHLTC received a Critical Incident System (CIS) report, which outlined an incident of alleged staff to resident abuse towards the identified resident, occurring on a specified date, by a specific staff member. The CIS report noted that the specific staff member was identified as being negatively associated with the resident. The report continued to state that at the time of the home becoming aware of the association between the identified resident and the specific staff member, the home discussed with the staff member alternative arrangements for working location. The staff member was reported to have sought legal counsel with the results allowing the staff member to work throughout the home. It was reported to the Director of Care (DOC) on a specific date that the staff

member had been speaking to the resident which resulted in the resident requesting a change in trajectory of care, as the resident was fearful to go to a specified location. Police were reported to be notified of the incident and visited the home.

Review of a progress note from a specific date by the DOC under the identified resident's profile stated in part, that the resident was upset and afraid to go to the specified location as someone had told them specific information, and the resident was afraid to be alone.

Review of the identified resident's Care Plan at the time of the incident noted no direction related to the resident's safety needs for potential emotional stressors.

During an interview with one staff member, they stated that there was a meeting held for staff at an identified time, which included the home's management team, related to the specific resident's safety care needs and the specified staff member's involvement with the resident. During the interview with the staff member, they stated that management did not follow through with the care needs discussed during the meeting and that the identified staff member was working throughout the building, including the care area of the specific resident. Inspector requested the staff member to review the identified resident's care plan and asked if the staff member would be able to state the resident's safety care needs at the time of the incident. The staff member stated there was nothing for staff to follow related to the safety care needs for the resident and if staff were not present the day that management held the meeting, they would not have been aware.

During an interview with another staff member, they stated that they and other staff members brought their concerns forward to management at a specified time about the specific staff member being in the care area of the identified resident. They stated that there was no follow up to their concerns at that time. On the day of the incident, as outlined in the CIS report, the staff member being interviewed stated that they had witnessed the specific staff member speaking with the identified resident, resulting in the resident becoming visually and verbally distraught. During the interview, the staff member stated that they believe that this interaction between the specific staff member towards the identified resident was threatening. When asked if they believed that the home had done enough to protect this resident from the potential of emotional or verbal abuse, the staff member stated no.

During an interview with another staff member, they stated that they had gone to the Administrator with concerns related to the identified resident's safety in the home and the specific staff member's access to the resident. The staff member continued to state that

management had organized a meeting where it was discussed that the specific staff member would be working on the other side of the building from the identified resident. The staff member stated that the specific staff member was then scheduled on the identified resident's side of the building. They stated that it was witnessed by another staff member the day of the incident the specified staff member spoke to the resident and the resident became visually upset and distraught. The staff member stated that they felt as though the interaction was calculated as the specified staff member left the building shortly after the witnessed incident. When asked if they felt like the home did enough to protect the identified resident from this incident, the staff member stated "absolutely not". When asked if they felt the home could have prevented the incident, the staff member stated the home could have prevented it.

During an interview with the Director of Care (DOC), when asked what they considered to be emotional abuse, they stated that causing a resident to be uncomfortable, making them teary, and saying things that would scare a resident would be considered emotional abuse. When asked if a CIS report is submitted with every concern that is brought forward, the DOC stated they try to. When asked about the identified resident, the DOC stated that there was an incident in which a specific staff member had spoken to the identified resident, resulting in the resident becoming fearful. When asked about the circumstances leading up to the incident that was reported in the CIS report, the DOC stated that they were made aware of these circumstances surrounding the resident at a specified time. The DOC stated that a specified staff member, was reported to have been negatively associated with the resident. It was at this time that management had spoken with the specified staff member to request that they work on the other side of the building. The DOC then stated that the specified staff member reported to management that they had conversations with their legal counsel which resulted in them being able to work wherever they wanted in the home. When the Inspector asked what was said or documented by the legal counsel to allow this, the DOC shrugged, acknowledged that the home had no documentation on record from the specified staff member's legal counsel, and stated that they did their best not to schedule that staff member on the identified resident's side of the building. When asked if the home took the specified staff member's word for it related to legal directive, they stated yes as they were short staffed and the staff member would be pulled sometimes. The DOC stated that the concern related to the specified staff member being in the care area of the identified resident was brought forward by another staff member to make them aware of circumstances outside of the home and the association between the specific staff member and the identified resident. When asked how the identified resident was after the incident occurred, as outlined in the CIS report, the DOC stated that the resident was upset and fearful, and

subsequently resulted in a change in the resident's trajectory of care. When asked if there was any concern from the home about the specific staff member being in the care area of the identified resident, the DOC stated that they took disciplinary action after the incident as that was when the concern arose. When the Inspector asked to see documentation about the concerns related to the specific staff member being in the care area of the identified resident, the DOC stated that there was nothing documented. When the Inspector asked the DOC how the home was ensuring that the specified staff member did not interact with the resident when they had identified that there was a potential for risk to the resident, the DOC stated that they would monitor the halls every so often and a meeting was held with staff to discuss the resident's safety needs. When asked how staff would know about the interventions and safety measures discussed during the meeting if they were not present for the meeting, the DOC stated that meeting minutes were posted in a specified location. They also stated that no staff were aware to monitor the interactions between the specified staff and the resident. When asked what interventions were in place and documented in the resident's plan of care to ensure their safety, the DOC stated that it was not documented and that it was word of mouth. When the Inspector asked what actions were taken as a result of this incident, the DOC stated that the specified staff member received disciplinary action and was required to sign the home's abuse policy upon return.

Review of a book titled "Complaints" provided by the Administrator, had nothing noted related to the identified resident in any specified years.

Review of the home's investigation notes as provided by the DOC included a hand written piece of paper with a specified date, which stated, in part, that the specific staff member was to stay on another wing of the building. Review of another hand written piece of paper with a specified date, found in the home's investigation notes stated, in part, that the specific staff member had gone to their legal counsel and could now work on any side of the building. Also a part of the investigation notes provided by the DOC included a hand written note with a specified date, outlining a discussion held between police, the specified staff member and management of the home. This note stated, in part, that the police recommended that the home take action towards specified staff member for their part in the incident and there would be no more interaction between the identified resident and the specific staff member or else resulting in criminal charges.

During inquiry interviews with the DOC and the Administrator, when asked what the home's process is when allegations of abuse or neglect are brought forward, the Administrator began speaking about their actions related to staff members. The

Administrator stated, in part, that their one regret was not disciplining the specified staff member more severely.

The licensee failed to ensure that the identified resident was protected from emotional and verbal abuse by the specified staff member, resulting in verbal and visual emotional distress, as well as a change in care trajectory, when the home was first made aware of the potential for risk of harm to the resident at a specified time and did not ensure all appropriate actions were taken to mitigate this risk. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone, or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

The Ministry of Health and Long-Term Care (MOHLTC) first received a Critical Incident System (CIS) report on a specified date, which outlined an incident of alleged staff to resident abuse of an identified resident occurring on a specific date.

Review of a progress note from a specific date, stated in part, that the identified resident had reported that they were upset and afraid after their interaction with a specified staff member.

During an interview with the Director of Care (DOC), when asked when they first became aware of the alleged staff to resident abuse they stated a specified date. The DOC continued to state that they should have reported the incident of alleged staff to resident abuse to the MOHLTC at the time they became aware. When asked when the MOHLTC first became aware of the incident, the DOC stated a specified date after the incident, via the CIS report.

The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone, or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director. When the DOC first became aware of the alleged staff to resident abuse of the identified resident on a specific date, it was not reported to the Director until a specified date after the incident, one business day later. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a person who has reasonable grounds to suspect that any of the following has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006, to be implemented voluntarily.

Issued on this 15th day of March, 2019

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

Original report signed by the inspector.

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KRISTEN MURRAY (731), AMBERLY COWPERTHWAITE (435)
Inspection No. / No de l'inspection :	2019_777731_0006
Log No. / No de registre :	030230-18, 030270-18, 003585-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 8, 2019
Licensee / Titulaire de permis :	Meritas Care Corporation 567 Victoria Avenue, WINDSOR, ON, N9A-4N1
LTC Home / Foyer de SLD :	Franklin Gardens Long Term Care Home 24 Franklin Road, LEAMINGTON, ON, N8H-4B7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shelley Dobson

To Meritas Care Corporation, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s.19 (1) of the LTCHA.

Specifically the licensee must:

1) Ensure all residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

2) Take immediate action when there is suspicion of alleged abuse and document all aspects of the investigation.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff.

Ontario Regulation 79/10 s.2 (1) defines “emotional abuse” as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident".

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resident’s safety in the home related to a specific staff member. The complainant alleged an incident of staff to resident abuse to the identified resident by the specified staff member.

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Review of a progress note from a specific date by the DOC under the identified resident’s profile stated in part, that the resident was upset and afraid to go to the specified location as someone had told them specific information, and the resident was afraid to be alone.

Review of the identified resident’s Care Plan at the time of the incident noted no direction related to the resident’s safety needs for potential emotional stressors.

During an interview with one staff member, they stated that there was a meeting held for staff at an identified time, which included the home’s management team, related to the specific resident’s safety care needs and the specified staff member’s involvement with the resident. During the interview with the staff member, they stated that management did not follow through with the care needs discussed during the meeting and that the identified staff member was working throughout the building, including the care area of the specific resident. Inspector requested the staff member to review the identified resident’s care plan and asked if the staff member would be able to state the resident’s safety care needs at the time of the incident. The staff member stated there was

nothing for staff to follow related to the safety care needs for the resident and if staff were not present the day that management held the meeting, they would not have been aware.

During an interview with another staff member, they stated that they and other staff members brought their concerns forward to management at a specified time about the specific staff member being in the care area of the identified resident. They stated that there was no follow up to their concerns at that time. On the day of the incident, as outlined in the CIS report, the staff member being interviewed stated that they had witnessed the specific staff member speaking with the identified resident, resulting in the resident becoming visually and verbally distraught. During the interview, the staff member stated that they believe that this interaction between the specific staff member towards the identified resident was threatening. When asked if they believed that the home had done enough to protect this resident from the potential of emotional or verbal abuse, the staff member stated no.

During an interview with another staff member, they stated that they had gone to the Administrator with concerns related to the identified resident's safety in the home and the specific staff member's access to the resident. The staff member continued to state that management had organized a meeting where it was discussed that the specific staff member would be working on the other side of the building from the identified resident. The staff member stated that the specific staff member was then scheduled on the identified resident's side of the building. They stated that it was witnessed by another staff member the day of the incident the specified staff member spoke to the resident and the resident became visually upset and distraught. The staff member stated that they felt as though the interaction was calculated as the specified staff member left the building shortly after the witnessed incident. When asked if they felt like the home did enough to protect the identified resident from this incident, the staff member stated "absolutely not". When asked if they felt the home could have prevented the incident, the staff member stated the home could have prevented it.

During an interview with the Director of Care (DOC), when asked what they considered to be emotional abuse, they stated that causing a resident to be uncomfortable, making them teary, and saying things that would scare a resident

would be considered emotional abuse. When asked if a CIS report is submitted with every concern that is brought forward, the DOC stated they try to. When asked about the identified resident, the DOC stated that there was an incident in which a specific staff member had spoken to the identified resident, resulting in the resident becoming fearful. When asked about the circumstances leading up to the incident that was reported in the CIS report, the DOC stated that they were made aware of these circumstances surrounding the resident at a specified time. The DOC stated that a specified staff member, was reported to have been negatively associated with the resident. It was at this time that management had spoken with the specified staff member to request that they work on the other side of the building. The DOC then stated that the specified staff member reported to management that they had conversations with their legal counsel which resulted in them being able to work wherever they wanted in the home. When the Inspector asked what was said or documented by the legal counsel to allow this, the DOC shrugged, acknowledged that the home had no documentation on record from the specified staff member's legal counsel, and stated that they did their best not to schedule that staff member on the identified resident's side of the building. When asked if the home took the specified staff member's word for it related to legal directive, they stated yes as they were short staffed and the staff member would be pulled sometimes. The DOC stated that the concern related to the specified staff member being in the care area of the identified resident was brought forward by another staff member to make them aware of circumstances outside of the home and the association between the specific staff member and the identified resident. When asked how the identified resident was after the incident occurred, as outlined in the CIS report, the DOC stated that the resident was upset and fearful, and subsequently resulted in a change in the resident's trajectory of care. When asked if there was any concern from the home about the specific staff member being in the care area of the identified resident, the DOC stated that they took disciplinary action after the incident as that was when the concern arose. When the Inspector asked to see documentation about the concerns related to the specific staff member being in the care area of the identified resident, the DOC stated that there was nothing documented. When the Inspector asked the DOC how the home was ensuring that the specified staff member did not interact with the resident when they had identified that there was a potential for risk to the resident, the DOC stated that they would monitor the halls every so often and a meeting was held with staff to discuss the resident's safety needs. When asked how staff would know about

the interventions and safety measures discussed during the meeting if they were not present for the meeting, the DOC stated that meeting minutes were posted in a specified location. They also stated that no staff were aware to monitor the interactions between the specified staff and the resident. When asked what interventions were in place and documented in the resident's plan of care to ensure their safety, the DOC stated that it was not documented and that it was word of mouth. When the Inspector asked what actions were taken as a result of this incident, the DOC stated that the specified staff member received disciplinary action and was required to sign the home's abuse policy upon return.

Review of a book titled "Complaints" provided by the Administrator, had nothing noted related to the identified resident in any specified years.

Review of the home's investigation notes as provided by the DOC included a hand written piece of paper with a specified date, which stated, in part, that the specific staff member was to stay on another wing of the building. Review of another hand written piece of paper with a specified date, found in the home's investigation notes stated, in part, that the specific staff member had gone to their legal counsel and could now work on any side of the building. Also a part of the investigation notes provided by the DOC included a hand written note with a specified date, outlining a discussion held between police, the specified staff member and management of the home. This note stated, in part, that the police recommended that the home take action towards specified staff member for their part in the incident and there would be no more interaction between the identified resident and the specific staff member or else resulting in criminal charges.

During inquiry interviews with the DOC and the Administrator, when asked what the home's process is when allegations of abuse or neglect are brought forward, the Administrator began speaking about their actions related to staff members. The Administrator stated, in part, that their one regret was not disciplining the specified staff member more severely.

The licensee failed to ensure that the identified resident was protected from emotional and verbal abuse by the specified staff member, resulting in verbal and visual emotional distress, as well as a change in care trajectory, when the

home was first made aware of the potential for risk of harm to the resident at a specified time and did not ensure all appropriate actions were taken to mitigate this risk.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 3 compliance history as they had one or more non-compliance with this section of the LTCHA that included:
- Voluntary Plan of Correction (VPC) issued July 15, 2016 (2016_257518_0028)
(435)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 8th day of March, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Kristen Murray

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