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**

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## Public Copy/Copie 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 |
|---|---|---|---|
| Dec 2, 2021 | 2021_831211_0019 | 012031-21, 012526-21, 015690-21 | Critical Incident System |

### Licensee/Titulaire de permis

CVH (No. 4) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Cambridge ON N3H 5L8

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

Manoir Marochel
949 Montreal Road Ottawa ON K1K 0S6

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

JOELLE TAILLEFER (211)

## 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): October 28, 29, 2021, November 1, 2, 3, 4, 5, 2021 (onsite) and November 8, 9, 2021 (offsite).**

**During this inspection the following logs were inspected:**
**Log #012031-21 related to allegation of abuse, and**
**Logs #012526-21 and #015690-21 related to a resident's fall that caused an injury to the resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Office Manager, Program Manager, Resident Assessment Instrument-Minimum Data Set Coordinator (RAI-MDS Coordinator), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSWs), Nursing Clerk, Recreation Aide and residents.**

**The inspectors reviewed several residents' health care records, licensee investigation notes, policies #RC-02-01-03 titled "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences" dated April 2017, #RC-14-01-01 titled "Continence Management Program" dated February 2017, #RC-07-01-01 titled "Resident Care Equipment" dated February 1, 2020, #RC-06-01-02 titled "Bathing, Showering and Water Temperature Monitoring" dated June 5, 2018, #RC-15-01-01 titled "Falls Prevention and Management Program" dated December 2020, Education Status Report-2020 and 2021 and observation of provision of care.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Falls Prevention**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**

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

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

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

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

**Specifically failed to comply with the following:**

**s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a resident's written plan of care sets out clear directions to staff and others who provide direct care to the resident.

The DOC stated that a resident was refusing care from some employees.

Review of the resident's care plan did not indicate that the resident did not want to have direct care from some employees.

The DOC validated that this information was not included in the resident's plan of care.

The Administrator acknowledged that this information should have been part of the resident's care plan.

As such, there was a potential risk that the resident receive care from some of the staff members as the resident's plan of care did not have clear directions to staff and others who provide direct care to the resident.

Sources: Review of the resident's health care records. Interviews with the Administrator, DOC, a staff member and the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that there was a written care plan for a resident that

sets out clear directions to staff and others who provide direct care to the resident related to hourly comfort rounds.

Review of a resident's health care records indicated that the resident was found lying on the floor on a date in 2021. The resident's care plan identified the resident as a fall risk.

The RAI coordinator stated that hourly comfort rounds done by staff was not documented in the resident's written care plan to provide clear directions to staff and others who provide direct care to the resident who was already identified at risk for fall. However, the Point of Care (POC) where the staff members document the resident's care indicated to monitor comfort hourly rounds.

The Administrator validated that the staff member assigned to the resident had not performed hourly comfort rounds on a date in 2021, for approximately an hour and forty-six minutes. Another staff member observed the resident sitting on the toilet during that time. The staff member left the resident unattended in the bathroom. The resident fell and was found on the floor by a third staff member.

The licensee failed to ensure that the resident's written care plan sets out clear directions to staff and others who provide direct care to the resident regarding the hourly comfort rounds. Subsequently, there was an actual fall risk of harm when the resident was not monitored hourly and consequently the resident was found on the floor.

Sources: Review of resident's health care record, investigation notes and interviews with a staff member and the Administrator. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided as specified in the plan for:
-a resident related to continence care and comfort hourly rounds, and
-another resident indicating that the resident required extensive assistance by two staff members during bathing.

1. A resident sustained a fall on a date in 2021 after being left on the toilet. The resident's health care records indicated that the resident was found lying on the floor. The resident sustained injuries.

The resident was transferred to the hospital several days later after the fall because the resident's health condition was not improving after being diagnosed with another health

issue. The resident returned to the home with a diagnosis of an injury and another health condition.

Upon Inspector #211 review of the resident's health care records and the licensee's investigation notes indicated that the care set out in the resident's plan of care was not provided as specified in the plan.

Prior to the resident's fall on a date in 2021, the following written plan of care for the resident was developed and implemented:
-The resident's progress notes written by the physiotherapist prior the resident's fall indicated that the resident had difficulty weight bearing and to follow commands. The requirement was to transfer the resident with an identified device.
-Within the resident's care plan initiated two months prior the resident's fall, the plan indicated that the resident was identified as a fall risk and required the assistance of two staff members and a specific device for transfer. Furthermore, the resident required total assistance by one staff member for pushing the wheelchair due to physical and cognitive impairment. The resident was using incontinence product for continence care and bowel management. The resident required total assistance during toileting. The resident needed to be changed in the bed and toileted every two to three hours.
-The Point of Care (POC) indicated to perform the comfort hourly rounds.

The fall assessment completed under the "Fall Management" in the resident electronic health care records for three days after resident's fall, indicated that there was no change in resident's functional and cognitive status nor in the resident range of motion. The resident's pain was assessed, and no pain issues reported by the resident or identified.

The licensee investigation notes indicated that two staff members transferred the resident into the wheelchair using an identified device after providing the morning care on a date in 2021. The staff member assigned to the resident on that shift indicated bringing the resident's breakfast tray early in the morning. The resident was repositioned in the wheelchair approximately one hour and a half later and observed sitting in the wheelchair at approximately twenty minutes later. A second staff member went to the resident's bedroom and observed that the resident was sitting on the toilet at approximately twenty-five minutes later. The staff member left the resident sitting on the toilet because the resident expressed the need to stay longer. The staff member who was assigned to the resident on that shift was informed by a Registered Nursing Staff that the resident was found on the floor.

Interview with the second staff member stated that the resident was observed sitting on the toilet in their bathroom at approximately one hour and twenty minutes prior the resident’s fall. The resident was left sitting on the toilet because the resident requested to stay longer. The staff member assigned to the resident on that shift stated that the resident's incontinent product was only changed in bed. The resident was not supposed to be sitting on the toilet. Both staff members stated they were unaware how or who could have brought the resident to the toilet.

The Administrator stated that the resident was not monitored hourly by the staff member who was assigned on that shift for the resident care. The last time the assigned staff member monitored the resident was over an hour. The resident was not provided continence care every two to three hours after providing resident’s care in the early morning. The resident was left unattended sitting on the toilet by the staff member who was assigned as the co-worker for the other staff member.

Subsequently, there was actual harm inflicted to the resident due to the fall since the comfort hourly rounds and continence care were not provided to the resident as specified in the resident’s plan of care.

Sources: Review of the resident’s health care records including the “Fall Management” assessment and the investigation’s notes. Interviews with two staff members and the Administrator.

2. A resident’s care plan created on a date in 2021, indicated that the resident required extensive assistance by 2 staff members during bathing. Review of the resident’s electronic health care record one month later, indicated that the resident had a fall with no injury while providing bathing.

The resident’s progress notes written by a Registered Nursing Staff on the next day, indicated that 2 staff members should have been present while providing bathing to the resident. The Registered Nursing Staff stated that there was only one staff member bathing the resident on that day.

The resident sustained a fall without injury as the resident's plan of care was not followed when only one staff member assisted with the resident's bathing.

Sources: Review of resident’s progress notes, post-fall assessment and risk management documentation. Interviews with two Registered Nursing Staff. [s. 6. (7)]

***Additional Required Actions:***

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

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**WN #2: 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 :**

1. The licensee has failed to ensure that where the Act or Regulation require the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that this policy is complied with.

Specifically, the licensee did not comply with the licensee's policy #RC-15-01-01 "Falls Prevention and Management Program" dated December 2020, that indicated the following: "If a resident is suspected of hitting their head (e.g., unwitnessed fall), complete Clinical Monitoring Record, Appendix 6. The Clinical Monitoring Record, Appendix 6, indicated to "Monitored the following every hour x 4 hours then every 8 hours x 72 hours;
• Neurovital Signs (If head/brain injury suspected or the fall is unwitnessed)
• Monitor vital Signs
• Assess for pain
• Monitor for Changes in Behavior".

On a date in 2021, a resident was found on the floor by their chair. The fall had not been witnessed by staff. A review of the Clinical Monitoring Record indicated that Neurovital Signs for the resident were monitored for the initial 40 hours post-fall incident.

The RAI Coordinator validated that the monitoring of the Neuro-vital Signs was not monitored and documented for 72 hours as per the Clinical Monitoring Record, Appendix 6.

As such, the Registered Nursing staff did not complete the 72 hours as per the Clinical Monitoring Record, Appendix 6, as indicated in the above "Falls Prevention and Management Program" policy.

Sources: Review of resident's health care records. Interviews with the RAI Coordinator. [s. 8. (1) (b)]

***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 where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with, to be implemented voluntarily.***

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**WN #3: 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 a post-fall assessment was performed following a resident's fall on a date in 2021.

Review of a resident's health care records indicated that the resident had fallen from a mobility device on a date in 2021. The documentation in the resident's health care record indicated that a Registered Nursing staff received a call from a staff member advising them that the resident had fallen. The resident was unable to inform the Registered Nursing Staff how the incident occurred.

A Registered Nursing Staff validated that the resident's post fall assessment was not conducted using the clinically appropriate assessment instrument tool.

As such, since the post-fall assessment was not completed for the resident on that day, potential risk factors contributing to the fall were not evaluated to prevent further fall incidences.

Sources: Review of resident's health care records, interviews with two Registered Nursing Staff. [s. 49. (2)]

2. The licensee has failed to ensure that a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls when a resident fell on a date in 2021.

Review of the resident's health care records indicated that the resident was found lying on the floor on a date in 2021. The resident's sustained two injuries.

A Registered Nursing Staff validated that a post-fall assessment was not completed on that date.

As such, since the post-fall assessment was not completed for the resident, potential risk factors contributing to the fall were not evaluated to prevent further fall incidences.

Sources: Review of resident's health care records and interviews with two staff members and a Registered Nursing Staff. [s. 49. (2)]

***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 when a resident has fallen, the resident was assessed, and a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control practice program when a staff member didn't assist residents with their hand hygiene after their meal.

On a date in 2021, Inspector #211 observed several alcohol-based hand sanitizer (ABHS) placed on a table beside the door of the dining room. A staff member was observed to be pushing a resident wheelchair out of the dining room. The resident's hands were not sanitized. Inspector #211 needed to remind the staff that resident's hands needed to be sanitized before exiting the dining room. The resident's hands were then sanitized.

Interview with a Registered Nursing Staff confirmed that staff members should assist residents to sanitize their hands.

Immediately after Inspector #211 observation, another staff member stayed by the door inside the dining room to encourage and ensure that all residents' hands were sanitized before exiting the dining room.

As such, residents were placed at risk for transmission of infection when the staff did not assist a resident with their hands' hygiene after their meal.

Sources: Interviews with a staff member and a Registered Nursing Staff. Observation by Inspector #211. [s. 229. (4)]

***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 all staff participate in the implementation of the infection prevention and control practice program when a staff member didn't assist residents with their hand hygiene after their meal, to be implemented voluntarily.***

**Issued on this 6th day of December, 2021**

**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**

## Public Copy/Copie du rapport public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l’inspecteur (No) :** | JOELLE TAILLEFER (211) |
| **Inspection No. / No de l’inspection :** | 2021_831211_0019 |
| **Log No. / No de registre :** | 012031-21, 012526-21, 015690-21 |
| **Type of Inspection / Genre d’inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Dec 2, 2021 |
| **Licensee / Titulaire de permis :** | CVH (No. 4) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)<br>766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, Cambridge, ON, N3H-5L8 |
| **LTC Home / Foyer de SLD :** | Manoir Marochel<br>949 Montreal Road, Ottawa, ON, K1K-0S6 |
| **Name of Administrator / Nom de l’administratrice ou de l’administrateur :** | Paul Beverley |

Ontario

**Ministry of Long-Term Care**

**Ministère 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

To CVH (No. 4) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.), 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**

**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

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**Order # / No d'ordre :** 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. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

**Order / Ordre :**

The licensee must comply with s. 6 (7) of the LTCHA, 2007.

Specifically, for all residents identified as risk for fall, the licensee shall:
- review and reassess the residents' plan of care related to hourly comfort round, continence care and bathing assistance to ensure that the staff members are following the care plan and,
- perform bi-weekly audits of the plan of care for 4 weeks for at least 3 different residents to assess the effectiveness of the interventions aimed at addressing the hourly comfort round, continence care, and bathing assistance, and
- document the audit results as well as the strategies implemented to effectively manage identified discrepancies to provide hourly comfort round, continence care and bathing assistance.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the care set out in the plan of care was provided as specified in the plan for:
-a resident related to continence care and comfort hourly rounds, and
-another resident indicating that the resident required extensive assistance by two staff members during bathing.

1. A resident sustained a fall on a date in 2021 after being left on the toilet. The resident's health care records indicated that the resident was found lying on the floor. The resident sustained injuries.

The resident was transferred to the hospital several days later after the fall because the resident's health condition was not improving after being diagnosed with another health issue. The resident returned to the home with a diagnosis of

an injury and another health condition.

Upon Inspector #211 review of the resident's health care records and the licensee's investigation notes indicated that the care set out in the resident's plan of care was not provided as specified in the plan.

Prior to the resident's fall on a date in 2021, the following written plan of care for the resident was developed and implemented:
-The resident's progress notes written by the physiotherapist prior the resident's fall indicated that the resident had difficulty weight bearing and to follow commands. The requirement was to transfer the resident with an identified device.
-Within the resident's care plan initiated two months prior the resident's fall, the plan indicated that the resident was identified as a fall risk and required the assistance of two staff members and a specific device for transfer. Furthermore, the resident required total assistance by one staff member for pushing the wheelchair due to physical and cognitive impairment. The resident was using incontinence product for continence care and bowel management. The resident required total assistance during toileting. The resident needed to be changed in the bed and toileted every two to three hours.
-The Point of Care (POC) indicated to perform the comfort hourly rounds.

The fall assessment completed under the "Fall Management" in the resident electronic health care records for three days after resident's fall, indicated that there was no change in resident's functional and cognitive status nor in the resident range of motion. The resident's pain was assessed, and no pain issues reported by the resident or identified.

The licensee investigation notes indicated that two staff members transferred the resident into the wheelchair using an identified device after providing the morning care on a date in 2021. The staff member assigned to the resident on that shift indicated bringing the resident's breakfast tray early in the morning. The resident was repositioned in the wheelchair approximately one hour and a half later and observed sitting in the wheelchair at approximately twenty minutes later. A second staff member went to the resident's bedroom and observed that the resident was sitting on the toilet at approximately twenty-five minutes later. The staff member left the resident sitting on the toilet because the resident

expressed the need to stay longer. The staff member who was assigned to the resident on that shift was informed by a Registered Nursing Staff that the resident was found on the floor.

Interview with the second staff member stated that the resident was observed sitting on the toilet in their bathroom at approximately one hour and twenty minutes prior the resident's fall. The resident was left sitting on the toilet because the resident requested to stay longer. The staff member assigned to the resident on that shift stated that the resident's incontinent product was only changed in bed. The resident was not supposed to be sitting on the toilet. Both staff members stated they were unaware how or who could have brought the resident to the toilet.

The Administrator stated that the resident was not monitored hourly by the staff member who was assigned on that shift for the resident care. The last time the assigned staff member monitored the resident was over an hour. The resident was not provided continence care every two to three hours after providing resident's care in the early morning. The resident was left unattended sitting on the toilet by the staff member who was assigned as the co-worker for the other staff member.

Subsequently, there was actual harm inflicted to the resident due to the fall since the comfort hourly rounds and continence care were not provided to the resident as specified in the resident's plan of care.

Sources: Review of the resident's health care records including the "Fall Management" assessment and the investigation's notes. Interviews with two staff members and the Administrator.

2. A resident's care plan created on a date in 2021, indicated that the resident required extensive assistance by 2 staff members during bathing. Review of the resident's electronic health care record one month later, indicated that the resident had a fall with no injury while providing bathing.

The resident's progress notes written by a Registered Nursing Staff on the next day, indicated that 2 staff members should have been present while providing bathing to the resident. The Registered Nursing Staff stated that there was only

one staff member bathing the resident on that day.

The resident sustained a fall without injury as the resident's plan of care was not followed when only one staff member assisted with the resident's bathing.

Sources: Review of resident's progress notes, post-fall assessment and risk management documentation. Interviews with two Registered Nursing Staff.

An order was made by taking the following factors into account:

Severity: One resident's plan of care related to toileting and comfort hourly rounds and another resident's plan of care in regard to bathing were not followed resulting in residents sustaining a fall.

Scope: These non-compliances were determined to be recurring patterns.

Compliance History: There was one written notification (WN), one voluntary plan of correction (VPC) and one compliance order (CO) issued under s. 6 (7) in July 2021, three written notifications (WN) in July 2021, one WN in October 2020 and one VPC in January 2020 issued to the home related to different subsections of the legislation in the past 36 months. (211)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Feb 16, 2022

## 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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON  M7A 1N3
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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 2nd day of December, 2021**

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

**Name of Inspector /**
**Nom de l'inspecteur :** Joelle Taillefer

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