



**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**

Central West Service Area Office  
500 Weber Street North  
WATERLOO ON N2L 4E9  
Telephone: (888) 432-7901  
Facsimile: (519) 885-9454

Bureau régional de services du  
Centre-Ouest  
500 rue Weber Nord  
WATERLOO ON N2L 4E9  
Téléphone: (888) 432-7901  
Télécopieur: (519) 885-9454

**Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Nov 28, 2018	2018_735659_0020	026441-18	Resident Quality Inspection

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**Licensee/Titulaire de permis**

CVH (No. 2) LP

766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Parkview Manor Health Care Centre

98 - 3rd Street South East P.O. Box 298 CHESLEY ON N0G 1L0

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

JANETM EVANS (659), MARIA MCGILL (728)

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**Inspection Summary/Résumé de l'inspection**

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de soins de longue durée***

**The purpose of this inspection was to conduct a Resident Quality Inspection.**

**This inspection was conducted on the following date(s): October 10, 11, 12, 15, 16, 17, 18 and 19, 2018.**

**Inspector Rhonda Ridgeway #737 attended this inspection.**

**The following follow up and intakes were completed in conjunction with the RQI:  
Log # 022560-18 Follow up to 2018\_735658\_0012 related to 24/7 nursing.  
Log #027469-18\Critical incident # 1053-000003-18 related to alleged abuse of a resident.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, Dietitian, Registered Nurses, Registered Practical Nurses, Person Support Workers, Office manager, Resident Council president, Family Council president, residents and family members.**

**During the course of the inspection the inspector(s) completed a tour of the home, made observations of provision of care, staff to resident interactions, medication administration and storage. Clinical records were reviewed, admission package for residents, flow sheets, relevant policies and procedures, training records, staffing schedules, minutes of Resident and Family council meetings.**

**The following Inspection Protocols were used during this inspection:**

**Dining Observation**

**Family Council**

**Infection Prevention and Control**

**Medication**

**Nutrition and Hydration**

**Personal Support Services**

**Prevention of Abuse, Neglect and Retaliation**

**Residents' Council**

**Skin and Wound Care**

**Sufficient Staffing**



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

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

<b>NON-COMPLIANCE / NON - RESPECT DES EXIGENCES</b>	
<p>Legend</p> <p>WN – Written Notification  VPC – Voluntary Plan of Correction  DR – Director Referral  CO – Compliance Order  WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit  VPC – Plan de redressement volontaire  DR – Aiguillage au directeur  CO – Ordre de conformité  WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>



**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services**

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

**s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with compliance order #001 from inspection #2018\_735659\_0012 served on July 18, 2018, with a compliance date of October 15, 2018, to ensure that there was at least one registered nurse who was an employee of the licensee and member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement.

Review of the home's schedule for 10 weeks in 2018, showed that 29 to 38 percent of the Registered Nurse (RN) shifts were covered by a Registered Practical Nurse (RPN). On five instances during this time period, the Director of Care (DOC) worked as the RN for day shifts.

The DOC stated that they currently had vacant positions for a RN; and acknowledged that they used a RPN as needed to cover RN shifts.

The licensee had failed to ensure that there was at least one registered nurse who was an employee of the licensee and member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement. [s. 8. (3)]

***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 LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**



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

- s. 23. (1) Every licensee of a long-term care home shall ensure that,**
- (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:**
    - (i) abuse of a resident by anyone,**
    - (ii) neglect of a resident by the licensee or staff, or**
    - (iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).**
  - (b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).**
  - (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported, is immediately investigated.

On a specified date, an identified resident alleged abuse by a Personal Support Worker (PSW). The resident stated they had reported the incident to the Executive Director (ED) and Director of Care (DOC).

On a specified date, the inspector notified the Executive Director (ED) of an allegation of ongoing abuse of an identified resident.

On a specified date, the ED stated they had not completed a critical incident related to this allegation and they had not had a conversation with the identified resident related to the alleged abuse.

The ED acknowledged that the expectation was that an immediate investigation should have been completed; and that this had not been done.

The licensee has failed to ensure that the alleged abuse of a resident was immediately investigated on the date it was reported to the ED and DOC. [s. 23. (1) (a)]



***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 an allegation of abuse is reported, it is immediately investigated, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

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

- s. 50. (2) Every licensee of a long-term care home shall ensure that,**
- (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
    - (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
    - (ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
    - (iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
    - (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**



1. The licensee has failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Review of the clinical record showed an assessment was completed which identified a specified resident had two areas of altered skin integrity. A weekly assessment was completed for one of the areas of altered skin integrity, however there was no further assessment noted related to the second area. The resident's care plan documented a resolved skin issue, however there was no assessment noted which related to the resolved skin issue.

Review of the Weekly Skin/Mouth Observation form completed by PSWs for four specified months showed the documentation was not consistently completed when the resident declined a bath. On a specified date, there was a notation made of an area of altered skin integrity being reported to the RN.

The Director of Care (DOC) said if an issue of altered skin integrity was identified, then they would initiate an assessment, do a progress note and initiate interventions. If interventions did not relieve the concern, a skin and wound assessment would be done. The DOC acknowledged the identified resident had not received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments. [s. 50. (2) (b) (i)]

***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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.***

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**WN #4: 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. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

Ontario Regulations 79/10, s. 4 defines a drug as " a substance or a preparation containing a substance referred to in clauses (a) through (d) of the definition of "drug" in subsection 1 (1) of the Drug and Pharmacies Regulation Act, including a substance that would be excluded from that definition by virtue of clauses (f) to (i) of that definition, but does not include a substance referred to in clause (e) of that definition. According to the definition from the Drug and Pharmacies Regulation Act, subsection 1 (1) a suppository meets the definition of a drug.

A Registered Nurse (RN) stated that Personal Support Workers (PSWs) administered a specified drug to residents and they signed for this in the daily care record binder on the PSW /HCA/ Nurses All treatment record.

Two PSWs acknowledged they had administered a drug to residents in the home.

The Director of Care acknowledged that PSWs administered a drug to residents in the home.

The licensee has failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. [s. 131. (3)]





***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 person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse, to be implemented voluntarily.***

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**WN #5: 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 staff participate in the implementation of the infection prevention and control program.

On a specified date, two inspectors observed a Personal Support Worker (PSW) dispose of a soiled incontinent product from their bare hands and then interact with three different residents prior to sanitizing their hands.

The PSW stated they must have forgotten to cleanse their hands and were too busy. They acknowledged the expectation for hand hygiene was to wash their hands between provision of care to each resident.

The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program. [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 staff participate in the implementation of the infection prevention and control program, specifically by ensuring that staff cleanse their hands between provision of care to residents, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

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

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**

- 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).**
- 2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).**
- 3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).**
- 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).**
- 5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).**
- 6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).**
- 7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).**
- 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).**
- 9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).**
- 10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).**
- 11. Every resident has the right to,**



- i. participate fully in the development, implementation, review and revision of his or her plan of care,
  - ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
  - iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
  - iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
- i. the Residents' Council,
  - ii. the Family Council,
  - iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
  - iv. staff members,



- v. government officials,
- vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
- 18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
- 19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
- 20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
- 21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
- 22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
- 23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
- 24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
- 25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
- 26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
- 27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

**Findings/Faits saillants :**



1. The licensee failed to ensure that every resident was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

On a specified date an identified resident reported that a Personal Support Worker (PSW) had hurt them in the provision of care. The identified resident said that they had not reported their concern to anyone previously and stated that they were afraid of the PSW.

A record review showed the identified resident was independent with a specified activity of daily living and if needed staff could provide assistance in the form of cuing and encouragement. The identified resident also required assistance with a second activity of daily living.

A review of the investigation completed by the home documented that the PSW stated that on one occasion the identified resident asked them to slow down because they were providing assistance too quickly and not in the correct manner. The resident had not complained that assistance with personal hygiene had been rough.

A Registered Nurse (RN) stated if a resident could verbalize that they were independent with an activity of daily living then staff should not go ahead and provide assistance. Residents have the right to be treated with dignity and respect.

The licensee failed to ensure that resident #003 was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respected the resident's dignity. [s. 3. (1)]

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**Rapport d'inspection prévue  
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de soins de longue durée***

**Issued on this 20th day of December, 2018**

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

**Original report signed by the inspector.**



**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

**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**

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**Name of Inspector (ID #) /**

**Nom de l'inspecteur (No) :** JANETM EVANS (659), MARIA MCGILL (728)

**Inspection No. /**

**No de l'inspection :** 2018\_735659\_0020

**Log No. /**

**No de registre :** 026441-18

**Type of Inspection /**

**Genre d'inspection:** Resident Quality Inspection

**Report Date(s) /**

**Date(s) du Rapport :** Nov 28, 2018

**Licensee /**

**Titulaire de permis :** CVH (No. 2) LP  
766 Hespeler Road, Suite 301, c/o Southbridge Care  
Homes, CAMBRIDGE, ON, N3H-5L8

**LTC Home /**

**Foyer de SLD :** Parkview Manor Health Care Centre  
98 - 3rd Street South East, P.O. Box 298, CHESLEY,  
ON, N0G-1L0

**Name of Administrator /**

**Nom de l'administratrice  
ou de l'administrateur :** Jake Presseault

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O. 2007, chap. 8

To CVH (No. 2) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:





**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  
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O. 2007, chap. 8

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**Order # /**

**Ordre no :** 001

**Order Type /**

**Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Linked to Existing Order /** 2018\_735659\_0012, CO #001;  
**Lien vers ordre existant:**

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

**Order / Ordre :**

The licensee must be compliant with s. 8 (3) of the LTCHA.

The licensee must ensure that at least one registered nurse who is both an employee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

**Grounds / Motifs :**



**Order(s) of the Inspector**

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O. 2007, chap. 8

1. The licensee has failed to comply with compliance order #001 from inspection #2018\_735659\_0012 served on July 18, 2018, with a compliance date of October 15, 2018, to ensure that there was at least one registered nurse who was an employee of the licensee and member of the regular nursing staff on duty and present at all times unless there was an allowable exception to this requirement.

Review of the home's schedule for 10 weeks in 2018, showed that 29 to 38 percent of the Registered Nurse (RN) shifts were covered by a Registered Practical Nurse (RPN). On five instances during this time period, the Director of Care (DOC) worked as the RN for day shifts.

The DOC stated that they currently had vacant positions for a RN; and acknowledged that they had used a RPN as needed to cover RN shifts.

The licensee had failed to ensure that there was at least one registered nurse who was an employee of the licensee and member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement.

The severity of this issue was level 2 as there was potential for actual harm to the residents. The scope was widespread with the potential to affect a large number of residents. The compliance history was level 5 as there were multiple non compliance with at least one related to the order. This legislation was previously issued as a compliance order on Jul 18, 2018 , inspection #2018\_735659\_0012 with a compliance due date of October 15, 2018; Nov 21, 2017, inspection #2017\_363659\_0025 with a compliance due date of January 31, 2018; October 17, 2016, inspection #2016\_508137\_0023 with a compliance due date of November 30, 2016; on May 4, 2016, inspection #2016\_262523\_0004 with a compliance due date of July 30, 2016; on June 22, 2015, inspection #2015\_259520\_0018 with a compliance due date of September 30, 2015. (659)

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

Mar 29, 2019



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

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**Ordre(s) de l'inspecteur**

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O. 2007, chap. 8

**REVIEW/APPEAL INFORMATION**

**TAKE NOTICE:**

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

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

The written request for review must include,

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

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

Director  
c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of 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:



**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

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](http://www.hsarb.on.ca).



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l'article 154 de la *Loi de 2007 sur les  
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O. 2007, chap. 8

**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, 11<sup>e</sup> étage  
Toronto ON M5S 2B1  
Télécopieur : 416-327-7603



**Ministry of Health and  
Long-Term Care**

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2007, c. 8

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l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.  
O. 2007, chap. 8

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 révision  
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](http://www.hsarb.on.ca).

**Issued on this 28th day of November, 2018**

**Signature of Inspector /**

**Signature de l'inspecteur :**

**Name of Inspector /**

**Nom de l'inspecteur :** JanetM Evans

**Service Area Office /**

**Bureau régional de services :** Central West Service Area Office