Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 28, 2019	2019_798738_0010	016737-18, 023192-18, 025435-18, 027109-18, 006534-19, 007204-19	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 8) 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 CAMBRIDGE ON N3H 5L8

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

Shelburne Long Term Care Home
200 Robert Street SHELBURNE ON L9V 3S1

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

AMANDA OWEN (738)

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): May 10, 14-15, 17, 21-24, 27-31, 2019.

The following intakes were completed in this Critical Incident System Inspection: Log #016737-18, Log #023192-18, Log #027109-18, Log #006534-19 and Log #007204-19, related to resident to resident abuse and Log #025435-18, related to Compliance Order (CO) #001 from inspection number 2018_742527_0014.

Complaint Inspection #2019_798738_0009, was also completed in conjunction with this inspection.

During the course of the inspection, the inspector(s) spoke with a Regional Director, Director of Care (DOC), Resident Services Coordinator (RSC), Behavioural Support Ontario (BSO) Lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Health Care Aides (HCA), Nurses Aides (NA), Activity Aides (AA) and residents.

The inspector also toured the home, observed resident care provision, staff to resident interactions, resident to resident interactions and completed record reviews.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
1 VPC(s)
2 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.

This was completed as a followup to CO #001 that was issued on October 10, 2018, during inspection #2018_742527_0014, related to duty to protect residents from abuse.

Ontario Regulation 79/10 s. 2 (1) defines “physical abuse” as the use of physical force by a resident that causes physical injury to another resident.

Ontario Regulation 79/10 s. 2 (1) defines “sexual abuse” as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long Term Care (MOHLTC), related to an incident of alleged abuse by resident#010 towards resident #011.

A Risk Management report showed that there was an altercation between resident #011 and resident #010, during which resident #010 was injured.

AA #111 said that they were running a program when resident #011 exhibited behaviours. During the time AA #111 left the room to get assistance, there was an altercation between resident #011 and co-resident #010.

Progress notes showed that resident #011 sustained an injury as a result of the incident.

A review of resident #010’s care plan showed that they had a history of specified behaviours directed towards others. AA #111 said that there were interventions in place to address the identified responsive behaviours.

B) The home submitted a CIS report to the MOHLTC, related to an incident of alleged abuse between residents #008 and #016.

Progress notes showed that a staff member observed resident #016 approach resident #008 in the hallway and exchange words with them. An altercation ensued and the staff member had to intervene. A RPN overheard the commotion and immediately attended to

the situation. The progress notes indicated that this was the second altercation between the two residents that day.

A Risk Management report showed that resident #008 sustained an injury because of the incident. DOC #102 said that resident #016 did not sustain any injuries.

DOC #102 said that resident #008 had a history of specified responsive behaviours. They said that at the time of the incident, an intervention was supposed to be in place to respond to the specified behaviours. However, records showed that this intervention was not implemented until after the incident occurred.

A review of resident #016's care plan showed that they had a history of specified responsive behaviours directed towards others. DOC #102 said that at the time of the incident, an intervention was in place to respond to the specified responsive behaviours. Records showed that this intervention was implemented at the time of the incident.

C) The home submitted a CIS report to the MOHLTC, related to an incident of alleged abuse by resident #008 towards resident #017.

Progress notes showed that a staff member entered a specified room and observed resident #008 exhibiting responsive behaviours towards resident #017.

HCA #104 said that they were passing by the specified room when something caught their eye. They said that upon entering the room they saw that resident #017 had an injury. Resident #017 informed them that they were just sitting there when resident #008 started an altercation.

A Risk Management report showed that resident #008 injured resident #017 during an unprovoked altercation.

DOC #102 said that resident #008 had a history of specified responsive behaviours directed towards others. They said that at the time of the incident, an intervention was supposed to be in place to respond to the specified behaviours. Records showed that this intervention was implemented at the time of the incident.

The licensee has failed to ensure that residents were protected from abuse by anyone.

The following is further evidence to support CO #001 that was issued on October 10,

2018, during inspection #2018_742527_0014.

A) The home submitted a CIS report to the MOHLTC, related to an incident of alleged abuse by resident #008 towards resident #007.

Risk Management reports showed that resident #008 initiated an altercation with resident #007.

Progress notes showed that resident #007 sustained an injury because of the incident.

RSC #101 said that resident #008 had a history of specified responsive behaviours. They said that they were not aware of any incidents of resident #007 displaying specified responsive behaviours towards others.

B) The home submitted a CIS report to the MOHLTC, related to an incident of alleged abuse by resident #006 towards resident #009.

RPN #110 said that a staff member informed them that they had observed resident #006 exhibit inappropriate behaviours towards resident #009.

A Risk Management report showed that resident #009 appeared to be upset after the incident, however they denied being harmed.

A document titled, Responsive Behaviour Debrief, showed that resident #006 had a history of a specified responsive behaviour directed towards others.

Progress notes showed that staff were to be implementing a specified intervention for resident #006 at the time of the incident. Records showed that this intervention was implemented at the time of the incident and that resident #006 was observed to be awake and calm just prior to the incident occurring. This intervention was not effective in maintaining the safety of resident #009.

The licensee has failed to ensure that residents were protected from abuse by anyone. [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 O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident’s admission to the home. O. Reg. 79/10, s. 24 (1).

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).
3. The type and level of assistance required relating to activities of daily living. O. Reg. 79/10, s. 24 (2).
4. Customary routines and comfort requirements. O. Reg. 79/10, s. 24 (2).
5. Drugs and treatments required. O. Reg. 79/10, s. 24 (2).
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. O. Reg. 79/10, s. 24 (2).
7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).
8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure a 24-hour admission care plan was developed for resident #016 and communicated to direct care staff within 24 hours of the resident being admitted to the home.

Resident #016 was admitted to the home for respite care on a specified date and

discharged on a specified date.

Resident #016's 24-hour admission care plan was not initiated/created until three days after they were admitted to the home.

RSC #101 said resident #016's 24-hour admission care plan was not completed as required.

The licensee has failed to ensure a 24-hour admission care plan was developed for resident #016 and communicated to direct care staff within 24 hours of the resident being admitted to the home. [s. 24. (1)]

2. The licensee has failed to ensure that the 24-hour admission care plans for residents #016, #018 and #019 included the following:

3. The type and level of assistance required relating to activities of daily living.
4. Customary routines and comfort requirements.
8. Diet orders, including food texture, fluid consistencies and food restrictions.

A) i) Resident #016 was admitted to the home for respite care on a specified date and discharged on a specified date.

Resident #016's 24-hour admission care plan showed it was not initiated/created until three days after they were admitted to the home, and it failed to identify the following:

3. The type and level of assistance required relating to activities of daily living.
4. Customary routines and comfort requirements.
8. Diet orders, including food texture, fluid consistencies and food restrictions.

A) ii) Resident #016 was admitted for a second time to the home for respite care on a specified date and discharged on a specified date.

Resident #016's 24-hour admission care plan showed it was initiated/created on a specified date, but it failed to identify the following:

4. Customary routines and comfort requirements.
8. Diet orders, including food texture, fluid consistencies and food restrictions.

B) Resident #018 was admitted to the home for respite care on a specified date and discharged on a specified date.

Resident #018's 24-hour admission care plan showed it was initiated/created on a specified date, but it failed to identify the following:

3. The type and level of assistance required relating to activities of daily living.
4. Customary routines and comfort requirements.
8. Diet orders, including food texture, fluid consistencies and food restrictions.

C) Resident #019 was admitted to the home for respite care on a specified date. The records showed that resident #019 was expected to be discharged from the home on a specified date.

Resident #019's 24-hour admission care plan showed it was initiated/created on a specified date, but it failed to identify the following:

3. The type and level of assistance required relating to activities of daily living.
4. Customary routines and comfort requirements.
8. Diet orders, including food texture, fluid consistencies and food restrictions.

RSC #101 stated that the 24-hour admission care plans for residents #016, #018 and #019 had not been completed as required.

The licensee has failed to ensure that the 24-hour admission care plans for residents #016, #018 and #019 included the following:

3. The type and level of assistance required relating to activities of daily living.
4. Customary routines and comfort requirements.
8. Diet orders, including food texture, fluid consistencies and food restrictions. [s. 24. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

The home submitted a CIS report to the MOHLTC, related to an incident of alleged abuse by resident #008 towards resident #016.

Progress notes showed that a staff member observed an altercation between resident #008 and resident #016.The progress notes indicated that this was the second altercation between the two residents that day.

DOC #102 said that resident #008 had a history of specified responsive behaviours directed towards others. Progress notes showed that resident #008 was involved in altercations with other residents on two other occasions.

DOC #102 said that at the time of the incident, an intervention was supposed to be in place to respond to resident #008's specified responsive behaviours. However, records showed that this intervention was not implemented until after the incident occurred.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions. [s. 54. (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 steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, to be implemented voluntarily.

WN #4: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan of care is no longer necessary.

Progress notes showed that residents #014 and #015 had formed a relationship. DOC #102 and BSO Lead #108 said both residents were cognitively aware and their relationship was consensual.

A review of resident #014's care plan showed that it failed to document that they were in a consensual relationship with resident #015.

A review of resident #015's care plan showed that they had a history of a specified responsive behaviour directed towards others and they previously required a specified intervention to be in place to address the behaviour. It failed to show that they were in a consensual relationship with resident #014.

BSO Lead #108 acknowledged that care plans of resident #014 and #015 did not identify their consensual relationship but should have.

The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan of care is no longer necessary. [s. 6. (10) (b)]

Issued on this 11th day of July, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDA OWEN (738)
Inspection No. / No de l'inspection :	2019_798738_0010
Log No. / No de registre :	016737-18, 023192-18, 025435-18, 027109-18, 006534-19, 007204-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 28, 2019
Licensee / Titulaire de permis :	CVH (No. 8) 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, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Shelburne Long Term Care Home 200 Robert Street, SHELBURNE, ON, L9V-3S1
	Heidi Vanderhorst

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur :

To CVH (No. 8) 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:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_742527_0014, CO #001;

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 shall ensure:

a) Residents #011, #016, 017 and all other residents, are protected from abuse from residents #008 and #010.

b) That interventions are developed and implemented for residents #010 and #008 when they are displaying responsive behaviours and there is documentation to support this.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

This was completed as a followup to CO #001 that was issued on October 10, 2018, during inspection #2018_742527_0014, related to duty to protect residents from abuse.

Ontario Regulation 79/10 s. 2 (1) defines "physical abuse" as the use of physical force by a resident that causes physical injury to another resident.

Ontario Regulation 79/10 s. 2 (1) defines "sexual abuse" as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long Term Care (MOHLTC), related to an incident of alleged abuse by resident #010 towards resident #011.

A Risk Management report showed that there was an altercation between resident #011 and resident #010, during which resident #010 was injured.

AA #111 said that they were running a program when resident #011 exhibited behaviours. During the time AA #111 left the room to get assistance, there was an altercation between resident #011 and co-resident #010.

Progress notes showed that resident #011 sustained an injury as a result of the incident.

A review of resident #010's care plan showed that they had a history of specified behaviours directed towards others. AA #111 said that there were interventions in place to address the identified responsive behaviours.

B) The home submitted a CIS report to the MOHLTC, related to an incident of alleged abuse between residents #008 and #016.

Progress notes showed that a staff member observed resident #016 approach resident #008 in the hallway and exchange words with them. An altercation ensued and the staff member had to intervene. A RPN overheard the commotion and immediately attended to the situation. The progress notes indicated that this was the second altercation between the two residents that day.

A Risk Management report showed that resident #008 sustained an injury because of the incident. DOC #102 said that resident #016 did not sustain any injuries.

DOC #102 said that resident #008 had a history of specified responsive behaviours. They said that at the time of the incident, an intervention was supposed to be in place to respond to the specified behaviours. However, records showed that this intervention was not implemented until after the incident occurred.

A review of resident #016's care plan showed that they had a history of specified responsive behaviours directed towards others. DOC #102 said that at the time of the incident, an intervention was in place to respond to the specified responsive behaviours. Records showed that this intervention was implemented at the time of the incident.

C) The home submitted a CIS report to the MOHLTC, related to an incident of alleged abuse by resident #008 towards resident #017.

Progress notes showed that a staff member entered a specified room and observed resident #008 exhibiting responsive behaviours towards resident #017.

HCA #104 said that they were passing by the specified room when something caught their eye. They said that upon entering the room they saw that resident #017 had an injury. Resident #017 informed them that they were just sitting there when resident #008 started an altercation.

A Risk Management report showed that resident #008 injured resident #017 during an unprovoked altercation.

DOC #102 said that resident #008 had a history of specified responsive behaviours directed towards others. They said that at the time of the incident, an intervention was supposed to be in place to respond to the specified behaviours. Records showed that this intervention was implemented at the time of the incident.

The licensee has failed to ensure that residents were protected from abuse by anyone.

The following is further evidence to support CO #001 that was issued on October 10, 2018, during inspection #2018_742527_0014.

A) The home submitted a CIS report to the MOHLTC, related to an incident of alleged abuse by resident #008 towards resident #007.

Risk Management reports showed that resident #008 initiated an altercation with resident #007.

Progress notes showed that resident #007 sustained an injury because of the incident.

RSC #101 said that resident #008 had a history of specified responsive behaviours. They said that they were not aware of any incidents of resident #007 displaying specified responsive behaviours towards others.

B) The home submitted a CIS report to the MOHLTC, related to an incident of alleged abuse by resident #006 towards resident #009.

RPN #110 said that a staff member informed them that they had observed resident #006 exhibit inappropriate behaviours towards resident #009.

A Risk Management report showed that resident #009 appeared to be upset after the incident, however they denied being harmed.

A document titled, Responsive Behaviour Debrief, showed that resident #006 had a history of a specified responsive behaviour directed towards others.

Progress notes showed that staff were to be implementing a specified intervention for resident #006 at the time of the incident. Records showed that this intervention was implemented at the time of the incident and that resident #006 was observed to be awake and calm just prior to the incident occurring. This intervention was not effective in maintaining the safety of resident #009.

The licensee has failed to ensure that residents were protected from abuse by anyone. [s. 19. (1)]
The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the residents. The scope of the issue was a 3 as it related three of three residents reviewed. The home had a level 4 history of non-compliance with this subsection of the Act that included:
- Written notification and voluntary plan of correction issued December 19, 2016 (2016_511586_0012)
- Written notification and compliance order issued October 10, 2018 (2018_742527_0014) (738)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 31, 2019

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.
3. The type and level of assistance required relating to activities of daily living.
4. Customary routines and comfort requirements.
5. Drugs and treatments required.
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions.
7. Skin condition, including interventions.
8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

Order / Ordre :

The licensee must be complaint with s.24(2) of Ontario Regulation 79/10. Specifically, the licensee shall ensure:

a) A 24-hour admission care plan is developed for each resident admitted to the home for respite care and communicated to the direct care staff within 24 hours of the resident's admission to the home.

b) Each care plan includes, at a minimum, the following with respect to the resident:

1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety.
3. The type and level of assistance required relating to activities of daily living.
4. Customary routines and comfort requirements.
5. Drugs and treatments required.
6. Known health conditions, including allergies and other conditions of which the licensee should be aware of upon admission, including interventions.
7. Skin condition, including interventions.
8. Diet orders, including food texture, fluid consistencies and food restrictions.

Grounds / Motifs :

1. The licensee has failed to ensure that the 24-hour admission care plans for residents #016, #018 and #019 included the following:

3. The type and level of assistance required relating to activities of daily living.
4. Customary routines and comfort requirements.
8. Diet orders, including food texture, fluid consistencies and food restrictions.

A) i) Resident #016 was admitted to the home for respite care on a specified date and discharged on a specified date.

Resident #016's 24-hour admission care plan showed it was not initiated/created until three days after they were admitted to the home, and it failed to identify the following:

3. The type and level of assistance required relating to activities of daily living.
4. Customary routines and comfort requirements.
8. Diet orders, including food texture, fluid consistencies and food restrictions.

A) ii) Resident #016 was admitted for a second time to the home for respite care on a specified date and discharged on a specified date.

Resident #016's 24-hour admission care plan showed it was initiated/created on a specified date, but it failed to identify the following:

4. Customary routines and comfort requirements.
8. Diet orders, including food texture, fluid consistencies and food restrictions.

B) Resident #018 was admitted to the home for respite care on a specified date and discharged on a specified date.

Resident #018's 24-hour admission care plan showed it was initiated/created on a specified date, but it failed to identify the following:

3. The type and level of assistance required relating to activities of daily living.
4. Customary routines and comfort requirements.
8. Diet orders, including food texture, fluid consistencies and food restrictions.

C) Resident #019 was admitted to the home for respite care on a specified date. The records showed that resident #019 was expected to be discharged from the home on a specified date.

Resident #019's 24-hour admission care plan showed it was initiated/created on a specified date, but it failed to identify the following:

3. The type and level of assistance required relating to activities of daily living.
4. Customary routines and comfort requirements.
8. Diet orders, including food texture, fluid consistencies and food restrictions.

RSC #101 stated that the 24-hour admission care plans for residents #016, #018 and #019 had not been completed as required.

The licensee has failed to ensure that the 24-hour admission care plans for residents #016, #018 and #019 included the following:

3. The type and level of assistance required relating to activities of daily living.
4. Customary routines and comfort requirements.
8. Diet orders, including food texture, fluid consistencies and food restrictions. [s. 24. (2)]

The severity of this issue was determined to be a level 1 as there was minimal risk to the residents. The scope of the issue was a 3 as it related four of four 24-hour admission care plans reviewed. The home had a level 2 history of non-compliance with this subsection of the Act. (738)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 25, 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 28th day of June, 2019

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Amanda Owen

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