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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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 15, 2019	2019_739694_0019	016610-19, 016816-19	Complaint

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 COULTER (694)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 12, 13, 17, 18, 19, and 20, 2019.

Log # 016816-19, IL-69877-CW, related to sufficient staffing and Log #016610-19, related to nutrition and hydration.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Resident Services Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nurse's Aides (NA), Substitiute Decision Makers (SDM), and residents.

The inspector also toured the home, observed the provision of care, meal and snack service, reviewed resident clinical records, reviewed personnel files, reviewed relevant policies and procedures and interviewed familiy members, residents and staff.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A complaint was received by the Ministry of Long-Term Care (MOLTC) in September 2019, related to the home's staffing and provision of care.

A review of the home's staffing plan for PSW's for the previous three months was completed and showed the following:
Days—a particular number of PSW's scheduled 0600-1400 hours;
Evenings—a particular number of PSW's scheduled 1400-2200 hours and;
Nights—a particular number of PSW's scheduled 2200-0600 hours.

During interviews with staff they shared that the home had recently changed their staffing plan.

Scheduling clerk #108 showed Long-Term Care Home (LTCH) inspector#694 a tracking

record of the PSW hours for each week. This record was shared at the daily management meeting and a copy was sent to the ED on a weekly basis by the scheduling clerk. A review of PSW hours related to the the complaint, for the specific months in the complaint.

For the period reviewed, the home had a specific number of vacant PSW hours.

Staffing clerk #108 said the vacant hours were the total hours not worked by PSW staff or agency.

During interviews with staff, they said they worked short staffed on a daily basis. When asked when the residents' baths were rescheduled, staff replied “they’re not”.

A resident shared that they did not get their bath on a number of occasions in the past couple of months. The resident said they were told there was not enough staff, they were working short. The resident also shared they waited up to 45 minutes for staff to take them to the washroom. They were not able to wait, which meant they had an accident and this made them feel “not very good”. The resident could not recall the date this occurred but it was within the past few months.

Review of the Point of Care (POC) documentation for the specific resident showed:
They missed a number of showers each month that was reviewed.

Another resident shared that they preferred three showers per week. When asked if they received at least two showers a week, the resident was annoyed and swore stating they did not get any showers. Staff told the resident they did not have time to do their shower because they were working short.

Review of the Point of Care (POC) documentation for the resident showed:
They missed a number of showers each month that was reviewed.

Another resident shared that they missed their bath often. On a certain date in September 2019, the LTCH inspector observed the resident ask staff to assist them to go to the washroom. Staff acknowledged the resident's request and stated they would have to find another staff member to assist. A significant amount of time later the resident told the inspector they were not assisted. The home was working two PSW’s short on that day.

Review of the Point of Care (POC) documentation for the resident showed:
They missed a number of showers each month that was reviewed.

Staff expressed they were not able to provide all the care the residents required. They also shared they were not able to toilet and change residents as often as needed.

The home's staffing plan evaluation showed the home's staffing plan, but did not include goals and objectives for 2019. The staffing plan changes were also not identified on the plan.

The licensee failed to ensure that the written staffing plan for the nursing and personal support services programs provided for a staffing mix that was consistent with residents' assessed care and safety needs.

In addition, they failed to ensure that the staffing plan was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. [s. 31. (3)]

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. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all written or verbal complaints made to the licensee or a staff member concerning the care of a resident or operation of the home were investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint and where the complaint alleges harm or risk of harm to one or more residents, the investigation commenced immediately.

The DOC received email correspondence on a specific date in July 2019, from a substitute decision maker (SDM) for a specific resident with care related concerns. The ED acknowledged they received a copy of the email from the DOC.

The home's investigation notes were reviewed. A response letter was sent to the SDM from the ED by email on a specific date in August 2019. Staff statements were collected by management after the response letter was sent to the SDM. There was no evidence that the resident's record was reviewed, that any staff were interviewed prior to responding to the complainant, or that an investigation was completed immediately.

LTCH inspector #694 asked the ED what the outcome of the home's investigation was and the ED said the investigation was still on-going and there had not been any further correspondence since sending the response letter to the resident's SDM.

The licensee failed to ensure that a written complaint made to the licensee concerning the care of resident #001 was investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint and where the complaint alleges harm or risk of harm to one or more residents, the investigation commenced immediately. [s. 101. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all written or verbal complaints made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint and where the complaint alleges harm or risk of harm to one or more residents, the investigation commenced immediately,, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

s. 212. (4) Subject to subsection (5), the licensee shall ensure that everyone hired as an Administrator after the coming into force of this section,
(a) has a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration; O. Reg. 79/10, s. 212 (4).
(b) has at least three years working experience,
(i) in a managerial or supervisory capacity in the health or social services sector, or
(ii) in another managerial or supervisory capacity, if he or she has already successfully completed the course mentioned in clause (d); O. Reg. 79/10, s. 212 (4).
(c) has demonstrated leadership and communications skills; and O. Reg. 79/10, s. 212 (4).
(d) has successfully completed or, subject to subsection (6), is enrolled in, a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time. O. Reg. 79/10, s. 212 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the administrator had a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration, had at least three years working experience in a managerial or supervisory capacity in the health or social services sector, or in another managerial or supervisory capacity, if he or she has already successfully completed a program in long-term care home administration or long-term care home management that is (in either case) a minimum of 100 hours in duration of instruction time, and had successfully completed or, subject to subsection (6), is enrolled in, a program in long-term care home administration or long-term care home management that is (in either case) a minimum of 100 hours in duration of instruction time.

Executive Director #100 said they had been hired as the permanent ED of the home and were enrolled in a Long-Term Care Homes management program.

A review of the employee's file showed they worked in positions that were not managerial or supervisory in nature and the ED did not have a post-secondary diploma or degree as required.

The licensee failed to ensure that the ED had the qualifications to be employed as the administrator of the home. [s. 212. (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 the administrator had a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration, had at least three years working experience in a managerial or supervisory capacity in the health or social services sector, or in another managerial or supervisory capacity, if he or she has already successfully completed a program in long-term care home administration or long-term care home management that is (in either case) a minimum of 100 hours in duration of instruction time, and had successfully completed or, subject to subsection (6), is enrolled in, a program in long-term care home administration or long-term care home management that is (in either case) a minimum of 100 hours in duration of instruction time,, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with LTCHA, 2007, s. 21, the licensee was required to ensure that there were written procedures that complied with the regulation for initiating complaints to the licensee and for how the licensee deals with complaints.

Specifically, the staff did not comply with the home's policy, "Complaints and Customer Service", which stated the home would provide residents, families, SDM's, staff and other stakeholders with its written process for obtaining information, raising concerns and lodging complaints regarding the home and its services. These processes would be posted in the home.

A complainant said they obtained the DOC contact information, specifically an email address, from a poster in the home.

The contact information for staff or visitors was outdated in June 2019 when resident's SDM submitted a written complaint to the home.

The licensee failed to ensure that the complaint and customer service policy was complied with, specifically that DOC contact information for reporting concerns or complaints was updated and made available in the home. [s. 8.]

WN #5: 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 following is further evidence to support the order issued on June 28, 2019, during Critical Incident System inspection 2019_798738_0010 to be complied July 31, 2019.

The licensee failed to ensure that residents were not neglected by the licensee or staff.

For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O. Reg. 79/10, s. 5.

A complaint was reported to the Ministry of Long-Term Care (MOLTC) on a specific date in August 2019, regarding an allegation of neglect by staff towards a resident.

On admission,verbally and in writing, the resident's family informed the home of specific interventions to provide continuity of care.

The resident had poor intake since admission and when assessed by the Registered Dietitian (RD) and the physician there were new interventions implemented to address the resident's decreased intake.

The RD did not identify the resident had intake well below the daily goals. The RD recommended staff continue with the interventions in place.

Dietary intake records in Point Click Care (PCC) for a specific period, showed the resident had poor intake and there were no interventions implemented to address the decreased intake.

The resident was experiencing a medical condition documented by registered staff, however, there were no interventions implemented to address the resident's medical condition.

On a specific date, registered staff assessed the resident's change of condition and transferred the resident to the hospital. The resident passed away the next day.

The licensee failed to provide treatment and care for dehydration, as well as notifying the physician & an SDM of declining intake that jeopardized the health and well-being of a resident. [s. 19. (1)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to immediately forward any written complaint that had been received concerning the care of a resident or the operation of the home to the Director.

The home received a complaint on a specific date in July 2019 from the SDM of a specific resident with care concerns.

In an interview with the ED, they said the complaint and response letter was forwarded to the Ministry of Long-Term Care. The ED provided a copy of the email correspondence, including a request by the Ministry that all correspondence was to be sent in a specific format. The ED said the complaint and response letter were submitted in a different format and they thought that meant "going forward".

The licensee failed to immediately forward a written complaint concerning the care of a resident to the Director. [s. 22. (1)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The SDM for a specific resident communicated in a written complaint that they believed quality care was not provided to support the resident's needs, related to nutrition and hydration, and that this may have contributed to the resident's death.

The ED said this was not reported to the Director as the DOC did not think it met the legislative requirements for reporting. The ED said they agreed with the DOC's opinion and a critical incident report was not completed.

The licensee failed to ensure that when resident's SDM alleged the resident was neglected which resulted in harm, an immediate report of the suspicion and the information upon which it was based was sent to the Director. [s. 24. (1)]

Issued on this 4th day of November, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	AMANDA COULTER (694)
Inspection No. / No de l’inspection :	2019_739694_0019
Log No. / No de registre :	016610-19, 016816-19
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 15, 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
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Stacey Rooyakkers

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

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

To 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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The licensee must be complaint with O. Reg. 79/10, s. 31 (3).

Specifically the licensee must:

a) Ensure the written staffing plan required for the organized program of nursing services under clause 8(1) (b) of the Act, provides for a staffing mix that is consistent with residents assessed care and safety needs.

b) Develop, document and implement a process in the home to evaluate whether the written staffing plan is consistently meeting the residents assessed care and safety needs in the home.
This evaluation must include:
i) An analysis of the care and safety needs of each group of residents in each section of the home which includes, but is not limited to, the residents' care needs related to Activities of Daily Living (ADLs) including bathing.
ii) An analysis of whether the written staffing plan for each section of the home, as per the staff assignment sheet, is meeting the care and safety needs of all residents living in the home.
iii) A documented record of the staffing plan evaluation which includes the date it was conducted, the names and signatures of the participants, the information analyzed, the results of the evaluation and what was done with the results of the evaluation.

c) Ensure the revised staffing plan, including the revised staffing back-up plan, is implemented and complied with.

Grounds / Motifs :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A complaint was received by the Ministry of Long-Term Care (MOLTC) in September 2019, related to the home's staffing and provision of care.

A review of the home's staffing plan for PSW's for the previous three months was completed and showed the following:

Days—a particular number of PSW's scheduled 0600-1400 hours;
Evenings—a particular number of PSW's scheduled 1400-2200 hours and;
Nights—a particular number of PSW's scheduled 2200-0600 hours.

During interviews with staff they shared that the home had recently changed their staffing plan.

Scheduling clerk #108 showed Long-Term Care Home (LTCH) inspector#694 a tracking record of the PSW hours for each week. This record was shared at the daily management meeting and a copy was sent to the ED on a weekly basis by the scheduling clerk. A review of PSW hours related to the the complaint, for the specific months in the complaint.

For the period reviewed, the home had a specific number of vacant PSW hours.

Staffing clerk #108 said the vacant hours were the total hours not worked by PSW staff or agency.

During interviews with staff, they said they worked short staffed on a daily basis. When asked when the residents' baths were rescheduled, staff replied “they’re not”.

A resident shared that they did not get their bath on a number of occasions in the past couple of months. The resident said they were told there was not enough staff, they were working short. The resident also shared they waited up to 45 minutes for staff to take them to the washroom. They were not able to wait, which meant they had an accident and this made them feel “not very good”. The resident could not recall the date this occurred but it was within the past few months.

Review of the Point of Care (POC) documentation for the specific resident showed:
They missed a number of showers each month that was reviewed.

Another resident shared that they preferred three showers per week. When asked if they received at least two showers a week, the resident was annoyed and swore stating they did not get any showers. Staff told the resident they did

not have time to do their shower because they were working short.

Review of the Point of Care (POC) documentation for the resident showed: They missed a number of showers each month that was reviewed.

Another resident shared that they missed their bath often. On a certain date in September 2019, the LTCH inspector observed the resident ask staff to assist them to go to the washroom. Staff acknowledged the resident's request and stated they would have to find another staff member to assist. A significant amount of time later the resident told the inspector they were not assisted. The home was working two PSW's short on that day.

Review of the Point of Care (POC) documentation for the resident showed: They missed a number of showers each month that was reviewed.

Staff expressed they were not able to provide all the care the residents required. They also shared they were not able to toilet and change residents as often as needed.

The home's staffing plan evaluation showed the home's staffing plan, but did not include goals and objectives for 2019. The staffing plan changes were also not identified on the plan.

The licensee failed to ensure that the written staffing plan for the nursing and personal support services programs provided for a staffing mix that was consistent with residents' assessed care and safety needs.

In addition, they failed to ensure that the staffing plan was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The severity of this issue was determined to be a level 2 as there was minimal harm or risk to the residents. The scope of the issue was a level 3 as it relates to all residents residing in the home. The home had a level 2 compliance history as there was previous NC to a different subsection.
(694)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Jan 03, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 15th day of October, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amanda Coulter

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