Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 8, 2021	2021_823653_0016	023895-20, 007935-21	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

Sherwood Court Long Term Care Centre
300 Ravineview Drive Maple ON L6A 3P8

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

ROMELA VILLASPIR (653)

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): June 25, 28, 29, and 30, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:
-Log #(s): 023895-20 and 007935-21, were related to falls resulting in injuries.

During the course of the inspection, the inspector(s) spoke with the Personal Support Workers (PSWs), Agency PSWs, Registered Practical Nurses (RPNs), Behavioural Support Ontario (BSO) RPN, Agency Registered Nurse (RN), Infection Prevention and Control (IPAC) Manager, Assistant Director of Care (ADOC), Housekeeper, Environmental Manager (EM), Director of Care (DOC), and the Executive Director (ED).

During the course of the inspection, the inspector toured the home, observed IPAC practices, provision of care, staff to resident interaction, reviewed clinical health records, staffing schedule, air temperature records, the home's investigation notes, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Training and Orientation

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 was free from neglect by Agency Personal Support Worker (PSW) #111 and Agency Registered Nurse (RN) #112.

The home submitted a Critical Incident Report (CIR) related to resident #001's fall which resulted in an injury and hospitalization.

A review of resident #001's clinical health records and an interview with Agency PSW #111 indicated the resident had an unwitnessed fall, and Agency RN #112 asked them to assist with lifting the resident from the floor, and transfer the resident to a transport wheelchair. Agency PSW #111 stated that the resident groaned and cried in discomfort when they were found on the floor, and later on when they changed the resident's continence product in bed. Further review of resident #001's clinical health records did not identify that the resident's discomfort was assessed, monitored, and addressed.

An interview with Assistant Director of Care (ADOC) #107 indicated they recalled reviewing the home's video surveillance and stated they did not see the RN physically assess the resident after finding them on the floor. The ADOC further stated the RN did not call the physician as required. The ADOC also confirmed that Agency PSW #111 and Agency RN #112 did not use a lift machine to transfer the resident from the floor to the transport wheelchair.

Further review of resident #001's clinical health records indicated 6.5 hours after the fall, during the following shift, the resident attempted to go to the washroom, but was not able to get up from the bed, and was screaming loud because of severe discomfort. The resident was sent to the hospital, and was diagnosed with an injury that required further treatment intervention.

Based on the staff interviews and record reviews, Agency RN #112 failed to conduct a proper post fall assessment and the RN also did not address the resident's complaints of discomfort, nor call the doctor about the fall. Furthermore, the RN and the PSW failed to safely transfer the resident from the floor to the transport wheelchair. During an interview, ADOC #107 acknowledged there was a delay in sending the resident to hospital for further assessment and treatment, and that the incident resulted in discomfort and injury to the resident.

Sources: Review of CIR, resident #001's clinical health records, the home's investigation notes; Interviews with ADOC #107, and agency staff. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #002 was reassessed, different approaches had been considered in the revision of their plan of care, because the care set out in the plan had not been effective.

The home had submitted a CIR related to resident #002's unwitnessed fall which resulted in an injury and hospitalization.

A review of resident #002's falls history documented under the Risk Management Module (RMM), revealed they had four previous falls within the last quarter. A review of the resident's care plan history including the resolved falls interventions, did not identify that different approaches were considered in revising their plan of care after they sustained the previous falls within the last quarter. An interview with Registered Practical Nurse (RPN) #114 indicated that resident #002's falls were mainly due to their responsive behaviours. An interview with Behavioural Support Ontario (BSO) RPN #117 confirmed they did not receive a referral for resident #002, and further indicated had they received one, they would have worked with recreation staff to learn resident #002's interests, identify new approaches to prevent them from falling, and include them in the plan of care.

An interview with ADOC #107 indicated that the risk associated to not considering different approaches in the revision of plan of care were potential fall incidents and injuries.

Sources: A review of CIR, RMM, and care plan; Interviews with RPN #114, BSO RPN #117, and ADOC #107. [s. 6. (11) (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 when a resident is reassessed and if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in writing, at a minimum, in at least two resident bedrooms in different parts of the home.

A review of Sherwood Court Building Daily Temperature readings - Common Areas and Halls documentation for the months of May 2021, and June 2021, indicated the three locations which temperature readings were measured and documented were: common, hall c, and hall d in the three home areas. During an interview, the Environmental Manager (EM) indicated that halls c and d included resident rooms. The EM showed the inspector the thermometer they used to read the temperature inside the resident rooms, and upon arriving in two home areas, it was noted that the thermometers were located on the wall, outside of the two residents' rooms. The EM removed the thermometers, placed them inside the rooms, and acknowledged that the air temperatures in the rooms were not measured as the thermometers were placed outside. Based on the review of the home's documentation, and the observation of the wall thermometers, there was not enough evidence to demonstrate that air temperatures were being measured and documented in writing in at least two resident bedrooms in different parts of the home.

During an interview, the Executive Director (ED) acknowledged that by not measuring and documenting the air temperatures in at least two resident bedrooms, the home may not be able to identify if there was a temperature concern, which may put residents at risk for developing a heat related illness.

Sources: Inspector #653's observations; Review of Sherwood Court Building Daily Temperature readings - Common Areas and Halls; Interviews with the EM, and ED. [s. 21. (2) 1.]

2. The licensee has failed to ensure that the temperatures required to be measured under subsection (2), were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

A review of Sherwood Court Building Daily Temperature readings - Common Areas and Halls documentation for the months of May 2021, and June 2021, identified air temperature measurements were only taken once a day, and not at the specified times as outlined in the legislation. An interview with the EM confirmed that they were in the process of switching to new documentation that would include day, evening, and night air temperature records.

During an interview, the ED indicated that the air temperatures in different parts of the home may change throughout the day, so it was important to measure and document the air temperatures at different times.

Sources: Sherwood Court Building Daily Temperature readings - Common Areas and Halls; Interviews with the ED, and ESM. [s. 21. (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 the temperature is measured and documented in writing, at a minimum, in at least two resident bedrooms in different parts of the home;
-to ensure that the temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that Agency PSW #100 received training in the areas provided for in the Act and the Regulation, before performing their responsibilities.

During an observation, Inspector #653 noted Agency PSW #100 did not adhere to appropriate Infection Prevention and Control (IPAC) practices. When questioned by the inspector if they received IPAC training from the home, the PSW stated they only received training from their agency. An interview with the IPAC Manager indicated they could not find Agency PSW #100's training records, and could not demonstrate that the PSW received the required training before performing their responsibilities in the home. An interview with ADOC #107 indicated that not training and educating staff prior to performing their responsibilities in the home, would be putting the residents and staff at risk.

Sources: Inspector #653's observation; Interviews with Agency PSW #100, IPAC Manager, and ADOC #107. [s. 76. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 1. The Residents' Bill of Rights. 2. The long-term care home's mission statement. 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 4. The duty under section 24 to make mandatory reports. 5. The protections afforded by section 26. 6. The long-term care home's policy to minimize the restraining of residents. 7. Fire prevention and safety. 8. Emergency and evacuation procedures. 9. Infection prevention and control. 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 11. Any other areas provided for in the regulations, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1.The licensee has failed to ensure that the home was a safe environment related to IPAC measures specified in Directive #3, regarding the appropriate use of Personal Protective Equipment (PPE).

The Chief Medical Officer of Health (CMOH) implemented Directive #3, which has been issued to Long-Term Care Homes (LTCHs), and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in LTCHs. As part of this directive, issued on June 4, 2021, LTCHs must ensure that essential visitors adhere to the IPAC recommendations for use of PPE for care of individuals with suspect or confirmed COVID-19.

The following observations were conducted by Inspector #653:

-An Essential Care Giver (ECG) entered a room that was on droplet/ contact precautions, and was within 2 Metres (M) of the resident. The ECG was only wearing a face mask.

-An ECG was in a room that was on droplet/ contact precautions. The ECG was sitting right beside the resident, within 2M in distance. ECG was not wearing a face shield, and their mask was resting on their chin.

During an interview, the IPAC Manager acknowledged the inspector’s observations, and indicated that the risk associated to the ECGs not adhering to the home’s IPAC practices, would be potential transmission of infection.

Sources: Inspector #653’s observations; Interview with the IPAC Manager. [s. 5.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's "Fall Prevention and Injury Reduction Program" policy was complied with.

According to O. Reg. 79/10, s. 49 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

A review of the home's policy titled "Fall Prevention and Injury Reduction Program", indicated under post-fall management procedure that if a fall is unwitnessed, a specific assessment is initiated for 72 hours.

The home had submitted a CIR related to resident #002's unwitnessed fall which resulted in an injury and hospitalization.

A review of resident #002's progress notes indicated they had an unwitnessed fall in their bedroom and was transferred to hospital 1.5 hrs later. A review of resident #002's assessment sheet revealed that it was not completed as scheduled prior to the resident going to the hospital. During an interview, ADOC #107 indicated that the assessment sheet was required to be completed in the time prescribed, and followed-up on.

Sources: Review of CIR, the home's Fall Prevention and Injury Reduction Program policy Resident #002's progress notes, and assessment sheet; Interviews with ADOC #107, and other staff. [s. 8. (1) (b)]

2. A review of resident #003's progress notes indicated they had an unwitnessed fall in their washroom. A review of their assessment sheet revealed that it was not completed as required.

During an interview, ADOC #107 indicated that the registered staff were required to complete the assessment sheet unless the resident refused, or it was indicated in their care plan. The ADOC stated that not completing the assessment sheet as part of the post fall assessment may result in missing potential injuries.

Sources: Review of the home's Fall Prevention and Injury Reduction Program policy, resident #003's progress notes, and assessment sheet; Interviews with ADOC #107, and other staff. [s. 8. (1) (b)]

WN #7: 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 the staff participated in the implementation of the home’s IPAC program.

The following observations were conducted by Inspector #653:

-An Agency PSW wearing full PPE exited from a resident’s room that was on droplet/ contact precautions, walked down the hallway towards the dining room, and then walked back to the room, doffed the gloves, and gown, and entered the room. The PSW donned new pair of gloves inside the room, and fixed the bed. The PSW exited the room still wearing gloves, walked down the hallway, and removed the gloves. The Agency PSW did not perform hand hygiene, did not change their mask, and did not disinfect their face shield.

-PSW #101 entered a room that was on droplet/ contact precautions, only wearing their face shield and face mask, and placed some items on the resident's bed. The PSW was within 2M of the resident.

During an interview, the IPAC Manager acknowledged the inspector’s observations, and indicated that the risk associated to the staff not adhering to the home’s IPAC practices, would be potential transmission of infection.

Sources: Inspector #653’s observations; Interview with the IPAC Manager. [s. 229. (4)]

2. During an observation, it was noted that a resident's room had a yellow PPE caddy hanging on their door, and a PPE disposable bin was by the door, however, there was no additional precautions signage posted on the door. A review of progress notes and an interview with RPN #113 indicated that the resident exhibited a symptom, and they were placed on isolation. The RPN acknowledged that the required additional precautions signage was not posted on the door at the time of the inspector's observation. An interview with the IPAC Manager indicated that the droplet/ contact precautions and donning/ doffing signages should have been posted on the resident's door. The IPAC Manager further indicated that not having the appropriate signage may not provide clarity on what precautions the staff would have to take when they enter the room.

Sources: Inspector #653's observation; Review of progress note; Interviews with RPN #113 and the IPAC Manager. [s. 229. (4)]

Issued on this 9th day of July, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	ROMELA VILLASPIR (653)
Inspection No. / No de l’inspection :	2021_823653_0016
Log No. / No de registre :	023895-20, 007935-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 8, 2021
Licensee / Titulaire de permis :	AXR Operating (National) LP, by its general partners c/o Revera Long Term Care Inc., 5015 Spectrum Way, Suite 600, Mississauga, ON, L4W-0E4
LTC Home / Foyer de SLD :	Sherwood Court Long Term Care Centre 300 Ravineview Drive, Maple, ON, L6A-3P8
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	James Zulueta

To AXR Operating (National) LP, by its general partners, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Order # / No d'ordre : 001

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

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 Long-Term Care Homes Act (LTCHA), 2007.

Specifically, the licensee must prepare, submit, and implement a plan to ensure that residents who sustain falls are not neglected. The plan must include:

1. Steps to ensure that when a resident has fallen, the registered nursing staff will conduct a post fall assessment to identify pain and potential injuries.

2. Measures to ensure the safe transfer of the resident following the registered nursing staff's post fall assessment.

3. Steps to ensure that the physician is notified regarding the fall incident, and informed of the registered nursing staff's post fall assessment findings in a timely manner.

4. A record is required to be kept by the licensee for all actions undertaken in items #1 to #3.

Please submit the written plan for achieving compliance for inspection #2021_823653_0016 to Romela Villaspir, LTC Homes Inspector, MLTC, by email, by July 23, 2021.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001 was free from neglect by Agency Personal Support Worker (PSW) #111 and Agency Registered Nurse (RN) #112.

The home submitted a Critical Incident Report (CIR) related to resident #001's fall which resulted in an injury and hospitalization.

A review of resident #001's clinical health records and an interview with Agency PSW #111 indicated the resident had an unwitnessed fall, and Agency RN #112 asked them to assist with lifting the resident from the floor, and transfer the resident to a transport wheelchair. Agency PSW #111 stated that the resident groaned and cried in discomfort when they were found on the floor, and later on when they changed the resident's continence product in bed. Further review of resident #001's clinical health records did not identify that the resident's discomfort was assessed, monitored, and addressed.

An interview with Assistant Director of Care (ADOC) #107 indicated they recalled reviewing the home's video surveillance and stated they did not see the RN physically assess the resident after finding them on the floor. The ADOC further stated the RN did not call the physician as required. The ADOC also confirmed that Agency PSW #111 and Agency RN #112 did not use a lift machine to transfer the resident from the floor to the transport wheelchair.

Further review of resident #001's clinical health records indicated 6.5 hours after the fall, during the following shift, the resident attempted to go to the washroom, but was not able to get up from the bed, and was screaming loud because of severe discomfort. The resident was sent to the hospital, and was diagnosed with an injury that required further treatment intervention.

Based on the staff interviews and record reviews, Agency RN #112 failed to conduct a proper post fall assessment and the RN also did not address the resident's complaints of discomfort, nor call the doctor about the fall. Furthermore, the RN and the PSW failed to safely transfer the resident from the floor to the transport wheelchair. During an interview, ADOC #107 acknowledged there was a delay in sending the resident to hospital for further assessment and treatment, and that the incident resulted in discomfort and injury to the resident.

Sources: Review of CIR, resident #001's clinical health records, the home's investigation notes; Interviews with ADOC #107, and agency staff.

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

Severity: There was actual risk of harm to resident #001 as the incident resulted in discomfort and injury to the resident, and there was a delay in sending the resident to hospital for further assessment and treatment.

Scope: This was an isolated case as no other incidents of neglect were identified during this inspection.

Compliance History: In the last 36 months, the licensee was found to be noncompliant with s. 19 (1) of the LTCHA, and a Written Notification (WN) and a Voluntary Plan of Correction (VPC) were issued to the home. (653)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
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 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 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 8th day of July, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Romela Villaspir

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