Ontario

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

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

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

**Rapport d'inspection 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 apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 5, 2016 | 2016_395613_0013 | 014172-16, 016848-16, 017716-16, 020253-16, 021544-16 | Complaint |

### Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

Extendicare Maple View of Sault Ste. Marie
650 Northern Avenue SAULT STE. MARIE ON P6B 4J3

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

LISA MOORE (613), SHEILA CLARK (617)

### 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): August 8- 12 and 15 - 17, 2016**

**This inspection was conducted as a result of five complaints received by the Director related to concerns regarding provisions of care.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Support Services Manager (SSM), Resident Assessment Instrument Coordinator (RAI Coordinator), Registered Nurses (RN & RPN), Personal Support Workers (PSW), Behavioural Supports Ontario Registered Practical Nurse (BSO RPN), Dietary Aides (DA) residents and family members.**

**During the course of the Complaint Inspection, the Inspectors conducted a daily walk through of the resident home areas and various common areas, made direct observations of the delivery of care and services provided to the residents, observed staff to resident interactions, reviewed resident health care records, staff training records and various policies, procedures and programs of the home.**

**A concurrent Critical Incident System Inspection #2016_395613_0014 was also conducted during this inspection.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Laundry**
**Falls Prevention**
**Nutrition and Hydration**
**Personal Support Services**

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

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

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

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

**s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #003 and the resident's substitute decision-maker (SDM) were given an opportunity to participate fully in the development and implementation of the of the resident's plan of care.

A complaint was received by the Director via the Action Line in May 2016 indicating that the SDM was not informed by the home that resident #003's medication dosage had been increased. The complainant identified that they had informed the home to never change resident #003's medications without notifying them first.

A review of the home's policy titled, "Treatment Consent", last revised on November 2005 revealed that if a resident lacks the capacity to make a decision regarding their care and treatment, an individual may be appointed to make the decisions on the resident's behalf. As well, persons seeking consent from a resident should document the consent in the resident's clinical record. Consent should be obtained by the person proposing the treatment, and consent should be obtained before treatment orders are written. Consent can be revoked by the incapable resident's SDM at any time.

A review of the Resident Assessment Instrument – Minimum Date Set (RAI-MDS) identified that resident #003 had moderately impaired cognition skills and poor decision making capabilities.

A review of the progress notes on Point Click Care did not reveal documentation that resident #003's SDM had been notified or provided the opportunity to participate in the resident's plan of care.

A review of the care plan did not reveal any documentation to notify the SDM for

medication changes. However, at the front of the paper chart, under the physician order tab was a bolded typed memo stating, “No medication changes without speaking to POA first." The sheet was not dated.

During an interview on August 16, 2016 with the Director of Care, they confirmed that the expectation for registered staff was to allow the SDM to participate fully in the development and implementation of the resident's plan of care; specifically, to notify the SDM of resident #003’s medication changes and document in the progress notes on point click care. [s. 6. (5)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident's #004, #005 and #006 as specified in the plan.

A complaint was received by the Director via the Action Line in July 2016, and a Critical Incident (CI) was submitted by the home in July 2016, regarding bruises found on resident #004.

On August 9, 2016, Inspector #617 interviewed the complainant, who identified that the bruising on resident #004 occurred during the night in July 2016.

A review of the home's investigation notes identified that the bruising on resident #004 occurred during the night in July 2016. The staff working during the night in July 2016 with resident #004 were interviewed by the Assistant Director of Care (ADOC) and PSW #107 had reported that they observed resident #004 having certain symptoms of a medical condition during that night. The home's investigation notes concluded that the bruise occurred as a result of certain symptoms of a medical condition resulting in injury to the resident.

A review of resident #004's health care record indicated that they were diagnosed with a certain medical condition, required the use of a wheelchair, were unable to communicate effectively, and were totally dependent on two staff members for assistance with activities of daily living.

A review of resident #004's care plan last revised in June 2016, indicated that when staff noticed a certain symptom of a medical condition, the registered staff were to monitor, provide a safe environment, and administer a medication. A review of resident #004's Medication Administration Record (MAR) indicated that a specific medication was ordered by the physician in June 2015, and was to be administered every four hours as

required for the medical condition.

A review of resident #004's MAR and progress notes for July 2016, did not indicate that the resident had a certain symptom of a medical condition or that a specific medication was administered. The review of resident #004's MAR and progress notes indicated that resident #004 historically received a treatment of a specific medication for a certain symptom of a medical condition on the following dates:

On two occasions in May 2016 and two occasions in July 2016.

Inspector #617 interviewed the ADOC, who confirmed that PSW #107 observed resident #004 have a certain symptom of a medical condition during the night of July 2016 and they did not report this observation to the registered staff. The ADOC stated that RPN #110 was on duty at the time of the incident, and had reported to them during the investigation that PSW #107 did not report observing a certain symptom of a medical condition. The ADOC stated it was the expectation that PSW #107 report the observation of any symptoms of a medical condition to the RPN. [s. 6. (7)]

3. A complaint from resident #005's Substitute Decision Maker (SDM) was received by the Director via the Action Line in June 2016, related to two separate occasions when the resident requested to be toileted by the staff and they had to wait long period of time which resulted in their incontinence.

Inspector #617 reviewed resident #005's health care record that indicated their diagnosis limited their mobility. A review of resident #005's Resident Assessment Instrument Minimum Data Set (RAI MDS) dated June 2016, indicated that they required a mechanical lift and extensive assistance with two staff for transferring; the wheelchair was their primary mode of locomotion; continent of both bladder and bowel; and used a scheduled toileting plan.

A review of resident #005's care plan dated July 2016, located at the nursing station, indicated that the resident was not able to toilet them self and required staff assistance due to their impaired mobility. The goal of the care plan indicated that resident #005 would receive the necessary assistance from the staff to maintain their ability to toilet. Interventions of resident #005's care plan indicated a toileting plan where the resident was to be toileted after all meals and prior to bed to promote continence.

During an interview with resident #005, they reported that their SDM visits with them

every day of the week. Resident #005 stated during these visits, their SDM assisted them to transfer to and from their wheelchair and the toilet at least twice during the day and once in the evening. They reported that staff assisted them to transfer to and from their wheelchair and the toilet using the mechanical lift in the morning when they got up and at night when they go to bed. Resident #005 confirmed that the staff had not offered or assisted them to the toilet after every meal.

During an interview with PSW #133, they confirmed to Inspector #617 that they were assigned to care for resident #005 on a certain day and required a mechanical lift to safely transfer to and from their wheelchair to the toilet. PSW #133 reported that they had assisted resident #005 only once during the shift on that day with another staff member to toilet in the morning after the resident got up from bed. PSW #133 confirmed that they had not offered or provided resident #005 assistance to the toilet after breakfast and lunch on that day.

Both the Inspector and PSW #133 reviewed resident #005's care plan together regarding the scheduled toileting plan. PSW #133 explained that for the past year, they had provided care to resident #005 and it was known that the resident's SDM would toilet the resident during the day. PSW #133 reported that they had not offered or provided toileting to resident #005 after breakfast and lunch on a certain day in August 2016 because the resident's SDM toileted them. PSW #133 then confirmed that they had not inquired to resident #005's SDM if they had provided toileting or how often it occurred.

The point of care documentation for the same day in August 2016 was reviewed for resident #005. It was documented that staff provided two person physical assistance to change the resident's continence care product, provided continence care and documented that the resident was continent of bladder once during the day.

Inspector #617 interviewed resident #005's SDM, who reported that they had provided the resident assistance to the bathroom twice on the certain day in August 2016, in the morning and afternoon, in which the resident had voided.

The home failed to provide the necessary assistance required to toilet resident #005 during the certain day in August 2016. [s. 6. (7)]

4. A complaint was received by the Director via the Action Line in May 2016, related to several concerns of the provision of care to resident #006. Inspector #617 interviewed the complainant who was concerned that the use of a fall intervention for resident #006

was a safety risk. The complainant was concerned that resident #006 could potentially injure them self.

A review of resident #006's Resident Assessment Instrument Minimum Data Set (RAI MDS) dated May 10, 2016, indicated that the resident's cognition was severely impaired; a wheelchair with a device to prevent rising was their primary mode of locomotion; they were able to self propel and required extensive assistance by one staff for activities of daily living.

A review of resident #006's care plan/kardex last revised in May 2016, indicated a fall prevention intervention which instructed the PSW to place the objects on the floor at night for safety and to put it away during the day when resident #006 was not in bed.

On August 9, 2016 and August 10, 2016 during the day shift, Inspector #617 observed resident #006 sitting in and propelling their wheelchair while in their room. Two objects were on the floor on either side of resident #006's bed.

During an interview with PSW #113, they reported that they had placed the objects on the floor on either side of resident #006's bed because resident #006 would be in the room several times during the day self propelling their wheelchair.

During an interview with the ADOC, they reported to the Inspector that they observed both objects on the floor on either side of resident #006's bed when the resident was up in their wheelchair. The ADOC directed PSW #113 to remove the objects off of the floor and place them aside not in the way of the resident while they were up in their wheelchair as per the care plan. The ADOC confirmed to the Inspector that the objects were on the floor on either side of resident #006's bed and should have been placed aside to prevent the resident from a potential injury while self propelling their wheelchair in their room. [s. 6. (7)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

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

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

A complaint was received by the Director via the Action Line in May 2016 indicating that the mini fridge in the activity room on a unit was not clean and that staff were not cleaning the mini fridge on a regular basis.

During the inspection, Inspector #613 observed the mini fridge to be unclean from August 9, 2016 to August 15, 2016. The mini fridge had dried brown substance on the bottom shelf, approximately three inch circumference and splatters of the dried brown substance on the second shelf, freezer compartment and inside of the door.

A review of an instruction sheet provided by the Administrator revealed that dietary staff was to monitor and clean the mini fridges on each unit daily.

During an interview on August 15, 2016 with the Administrator, they confirmed that mini fridges on each unit are expected to be cleaned daily by the dietary staff. [s. 15. (2) (a)]

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service**

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

**s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,**
**(a) procedures are developed and implemented to ensure that,**
**(i) residents' linens are changed at least once a week and more often as needed,**
**(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,**
**(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and**
**(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure resident #003's personal items and clothing were labelled in a dignified manner within 48 hours of admission and of acquiring in the case of new clothing.

A complaint was received by the Director via the Action Line in May 2016 indicating that most of resident #003's clothing were not labelled.

During an interview with the Support Service Manager #122, they stated that residents' clothing were to be brought to the laundry department in a labelled bag by the nursing staff to be labelled upon admission and upon acquiring new clothing. There was a form in the laundry department titled, "Personal Clothing Intake Record", that was completed by laundry staff to identify when a residents clothing was labelled.

Inspector #613 reviewed the home's policy titled, "Labelling of Personal Clothing" last revised on September 2015 which revealed that all resident personal clothing would be documented, labelled and returned to the resident within 48 hours of having been received by the home. The nursing and personal care staff were to ensure upon a resident's admission or when additional clothing was received that they delivered the resident's clothing to the laundry department for labelling.

On August 12, 2016, the Assistant Director of Care (ADOC) reported to the Inspector that they and another staff had gone through all of resident #003's clothing in their room and determined that three articles of clothing were not labelled.

During an interview on August 16, 2016 with the Director of Care, they confirmed that staff was expected to follow the home's policy and ensure that all residents' clothing were brought to the laundry department for labelling upon admission and acquiring new clothing. [s. 89. (1) (a) (ii)]

**Issued on this 7th day of October, 2016**

| |
|---|
| **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

**Ministére 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

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | LISA MOORE (613), SHEILA CLARK (617) |
| **Inspection No. / No de l'inspection :** | 2016_395613_0013 |
| **Log No. / Registre no:** | 014172-16, 016848-16, 017716-16, 020253-16, 021544-16 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Oct 5, 2016 |
| **Licensee / Titulaire de permis :** | EXTENDICARE (CANADA) INC.<br>3000 STEELES AVENUE EAST, SUITE 700,<br>MARKHAM, ON, L3R-9W2 |
| **LTC Home / Foyer de SLD :** | Extendicare Maple View of Sault Ste. Marie<br>650 Northern Avenue, SAULT STE. MARIE, ON,<br>P6B-4J3 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Johanne Messier-Mann |

To EXTENDICARE (CANADA) 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 :**

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

**Order / Ordre :**

The licensee shall,

-Ensure the care as set out in the plan of care for resident #004 is followed, specifically that PSWs are to report any certain symptoms of a medical condition to the registered staff.

-Ensure the care as set out in the plan of care for resident #005, related to toileting is followed.

-Ensure the care as set out in the plan of care for resident #006, related to fall prevention interventions is followed.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident's #004, #005 and #006 as specified in the plan.

A complaint was received by the Director via the Action Line in July 2016, and a Critical Incident (CI) was submitted by the home in July 2016, regarding bruises found on resident #004.

On August 9, 2016, Inspector #617 interviewed the complainant, who identified that the bruising on resident #004 occurred during the night in July 2016.

A review of the home's investigation notes identified that the bruising on resident #004 occurred during the night in July 2016. The staff working during the night in July 2016 with resident #004 were interviewed by the Assistant Director of Care (ADOC) and PSW #107 had reported that they observed resident #004

having certain symptoms of a medical condition during that night. The home's investigation notes concluded that the bruise occurred as a result of certain symptoms of a medical condition resulting in injury to the resident.

A review of resident #004's health care record indicated that they were diagnosed with a certain medical condition, required the use of a wheelchair, were unable to communicate effectively, and were totally dependent on two staff members for assistance with activities of daily living.

A review of resident #004's care plan last revised in June 2016, indicated that when staff noticed a certain symptom of a medical condition, the registered staff were to monitor, provide a safe environment, and administer a medication. A review of resident #004's Medication Administration Record (MAR) indicated that a specific medication was ordered by the physician in June 2015, and was to be administered every four hours as required for the medical condition.

A review of resident #004's MAR and progress notes for July 2016, did not indicate that the resident had a certain symptom of a medical condition or that a specific medication was administered. The review of resident #004's MAR and progress notes indicated that resident #004 historically received a treatment of a specific medication for a certain symptom of a medical condition on the following dates:

On two occasions in May 2016 and two occasions in July 2016.

Inspector #617 interviewed the ADOC, who confirmed that PSW #107 observed resident #004 have a certain symptom of a medical condition during the night of July 2016 and they did not report this observation to the registered staff. The ADOC stated that RPN #110 was on duty at the time of the incident, and had reported to them during the investigation that PSW #107 did not report observing a certain symptom of a medical condition. The ADOC stated it was the expectation that PSW #107 report the observation of any symptoms of a medical condition to the RPN. [s. 6. (7)]

2. A complaint from resident #005's Substitute Decision Maker (SDM) was received by the Director via the Action Line in June 2016, related to two separate occasions when the resident requested to be toileted by the staff and they had to wait long period of time which resulted in their incontinence.

Inspector #617 reviewed resident #005's health care record that indicated their diagnosis limited their mobility. A review of resident #005's Resident Assessment Instrument Minimum Data Set (RAI MDS) dated June 2016, indicated that they required a mechanical lift and extensive assistance with two staff for transferring; the wheelchair was their primary mode of locomotion; continent of both bladder and bowel; and used a scheduled toileting plan.

A review of resident #005's care plan dated July 2016, located at the nursing station, indicated that the resident was not able to toilet them self and required staff assistance due to their impaired mobility. The goal of the care plan indicated that resident #005 would receive the necessary assistance from the staff to maintain their ability to toilet. Interventions of resident #005's care plan indicated a toileting plan where the resident was to be toileted after all meals and prior to bed to promote continence.

During an interview with resident #005, they reported that their SDM visits with them every day of the week. Resident #005 stated during these visits, their SDM assisted them to transfer to and from their wheelchair and the toilet at least twice during the day and once in the evening. They reported that staff assisted them to transfer to and from their wheelchair and the toilet using the mechanical lift in the morning when they got up and at night when they go to bed. Resident #005 confirmed that the staff had not offered or assisted them to the toilet after every meal.

During an interview with PSW #133, they confirmed to Inspector #617 that they were assigned to care for resident #005 on a certain day and required a mechanical lift to safely transfer to and from their wheelchair to the toilet. PSW #133 reported that they had assisted resident #005 only once during the shift on that day with another staff member to toilet in the morning after the resident got up from bed. PSW #133 confirmed that they had not offered or provided resident #005 assistance to the toilet after breakfast and lunch on that day.

Both the Inspector and PSW #133 reviewed resident #005's care plan together regarding the scheduled toileting plan. PSW #133 explained that for the past year, they had provided care to resident #005 and it was known that the resident's SDM would toilet the resident during the day. PSW #133 reported that they had not offered or provided toileting to resident #005 after breakfast and lunch on a certain day in August 2016 because the resident's SDM toileted them. PSW #133 then confirmed that they had not inquired to resident #005's

SDM if they had provided toileting or how often it occurred.

The point of care documentation for the same day in August 2016 was reviewed for resident #005. It was documented that staff provided two person physical assistance to change the resident's continence care product, provided continence care and documented that the resident was continent of bladder once during the day.

Inspector #617 interviewed resident #005's SDM, who reported that they had provided the resident assistance to the bathroom twice on the certain day in August 2016, in the morning and afternoon, in which the resident had voided.

The home failed to provide the necessary assistance required to toilet resident #005 during the certain day in August 2016. [s. 6. (7)]

3. A complaint was received by the Director via the Action Line in May 2016, related to several concerns of the provision of care to resident #006. Inspector #617 interviewed the complainant who was concerned that the use of a fall intervention for resident #006 was a safety risk. The complainant was concerned that resident #006 could potentially injure them self.

A review of resident #006's Resident Assessment Instrument Minimum Data Set (RAI MDS) dated May 10, 2016, indicated that the resident's cognition was severely impaired; a wheelchair with a device to prevent rising was their primary mode of locomotion; they were able to self propel and required extensive assistance by one staff for activities of daily living.

A review of resident #006's care plan/kardex last revised in May 2016, indicated a fall prevention intervention which instructed the PSW to place the objects on the floor at night for safety and to put it away during the day when resident #006 was not in bed.

On August 9, 2016 and August 10, 2016 during the day shift, Inspector #617 observed resident #006 sitting in and propelling their wheelchair while in their room. Two objects were on the floor on either side of resident #006's bed.

During an interview with PSW #113, they reported that they had placed the objects on the floor on either side of resident #006's bed because resident #006 would be in the room several times during the day self propelling their

wheelchair.

During an interview with the ADOC, they reported to the Inspector that they observed both objects on the floor on either side of resident #006's bed when the resident was up in their wheelchair. The ADOC directed PSW #113 to remove the objects off of the floor and place them aside not in the way of the resident while they were up in their wheelchair as per the care plan. The ADOC confirmed to the Inspector that the objects were on the floor on either side of resident #006's bed and should have been placed aside to prevent the resident from a potential injury while self propelling their wheelchair in their room.

The decision to issue an order was based on the potential for actual harm to residents #004, #005 and #006. The scope was determined to be a pattern and there was a history of previous noncompliance identified during the following inspections:
-A voluntary plan of correction (VPC) was issued in the Resident Quality Inspection #2016_3395613_0007 served to the home on August 15, 2016;
-A written notification (WN) was issued in the Critical Systems Inspection #2014_380593_0006 served to the home on October 3, 2014;
-A voluntary plan of correction (VPC) was issued in the Resident Quality Inspection #2014_281542_0005 served to the home on March 28, 2014;
-A voluntary plan of correction (VPC) was issued in the Critical Systems Inspection #2014_281542_0007 served to the home on March 21, 2014.

(617)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 31, 2016

## 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 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
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La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

**Issued on this 5th day of October, 2016**

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

**Name of Inspector /**
**Nom de l'inspecteur :** Lisa Moore

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