



**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**

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de
Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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
Jun 27, 2018	2018_633577_0008	011618-18	Resident Quality Inspection

Licensee/Titulaire de permis

Atikokan General Hospital
120 Dorothy Street ATIKOKAN ON P0T 1C0

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

Atikokan General Hospital
120 Dorothy Street ATIKOKAN ON P0T 1C0

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

DEBBIE WARPULA (577), MELISSA HAMILTON (693), SHEILA CLARK (617)

Inspection Summary/Résumé de l'inspection



**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 sous la
Loi de 2007 sur les foyers de
soins de longue durée**

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

This inspection was conducted on the following date(s): June 18, 19, 20, 21 and 22, 2018.

The following intakes were inspected during this inspection:

- One Critical Incident System (CIS) report related to a resident fall; and**
- One CIS report related to allegations of resident physical abuse.**

During the course of the inspection, the inspector(s) spoke with the the President and Chief Executive Officer (CEO), Chief Nursing Officer (CNO), Acute Care/Emergency Department Nurse Manager, Nurse Manager of Extended Care Wing (ECW), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides (DA), Resident Assessment Instrument (RAI) Coordinator, Risk Management/Infection Control Lead, Clinical Consultant Pharmacist, residents and families.

The inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

**Continance Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours**



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

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that there was, at least quarterly, a documented reassessment of each resident's drug regime.

On June 20, 2018, Inspector #577 conducted a record review of resident #010's physician's orders, prior to the observation of a medication pass. Inspector #577 identified that resident #010 did not have a current quarterly reassessment of their drug regime. A review of the previous quarterly medication review was signed by the physician on a particular day in March 2018, and the authorization period was from March 1, to May 31, 2018. The current quarterly medication review with an authorization period dated June 1, 2018-August 31, 2018, had not been signed by the physician. A review of the Electronic Medication Administration Record (MAR) for resident #010 confirmed that staff had been administering resident #010's prescribed medication from June 1-20, 2018.

A review of the pharmacy provider medication policy "Prescriber Medication Orders - #2.2" revised January 17, 2017, indicated that each resident would have their medication (s) reviewed by the prescriber every three months; the review would be done via the Three Month Medication Review Form and a copy of the completed form would serve as the prescription for the resident's medication for three months.



A review of the pharmacy provider medication policy "Three Month Medication Review Check - #2.14" revised March 2017, indicated that each resident's medication orders were to be reviewed by the attending physician at least every 90 days; medication reviews served as prescriptions for the resident's medication during the three month duration indicated on the review.

A review of the unsigned quarterly medication reviews with an authorization period dated June 1, 2018, to August 31, 2018, indicated that a total of 24 residents were missing physician signatures authorizing the administration of the residents' medications for the period of June 1, to August 31, 2018. In total, 92 per cent of the residents in the home, did not have a current and valid prescription for administration of their medications that had been administered since June 1, 2018, and were currently being administered.

During an interview with Clinical Consultant Pharmacist #112, for the pharmacy provider, they reported that the three month medication reviews served as prescriptions and were considered 'expired' past their authorization date.

During an interview with the Chief Nursing Officer (CNO) #113, they reported that it was the expectation of the home that the physicians completed their three month medication review by the required time and it was a scheduling issue with the physicians.

During an interview with Nurse Manager #106, they reported that their process was to obtain a physician review and signature of the resident's quarterly medication review every quarter and were considered active orders until the physician reviewed and signed the next review. They confirmed that 24/26 or 92% of the residents, had expired authorization for the administration of the residents' medications for the period of June 1, to August 31, 2018. [s. 134. (c)]

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).

(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the care set out in the plan had not been effective.

A record review of resident #009's progress notes and the home's Line Listing, indicated that the resident was placed on special precautions on a day in June 2018, for their symptoms.

A review of resident #009's current care plan did not include any focus or intervention related to the resident being on special precautions.

Inspector #577 reviewed the home's policy "Plan of Care Policy" revised June 2018, indicated that the plan of care was to be reviewed and revised according to reassessment in collaboration with the resident/SDM and the interdisciplinary team when the resident's care needs changed.

During a staff interview with RPN #109, they reported that the registered staff and the Resident Assessment Instrument (RAI) Coordinator were responsible to update residents' care plans.

During a staff interview with RAI Coordinator #108, they reported that it was the responsibility of all registered staff to update residents' care plans. [s. 6. (10) (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 the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

- s. 129. (1) Every licensee of a long-term care home shall ensure that,**
- (a) drugs are stored in an area or a medication cart,**
 - (i) that is used exclusively for drugs and drug-related supplies,**
 - (ii) that is secure and locked,**
 - (iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
 - (iv) that complies with manufacturer's instructions for the storage of the drugs;**
 - and O. Reg. 79/10, s. 129 (1).**
 - (b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

Findings/Faits saillants :



1. The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard or stored in a separate locked area within the locked medication cart.

Inspector #577 conducted a controlled substance count with RPN #104 in the locked medication room. During the count, the Inspector observed RPN #109 enter the medication room. They opened their medication cart, removed a package of medication, placed it on top of the cart and exited the medication room.

Following the controlled substance count with RPN #104, Inspector #577 observed the other medication cart to have a package of Statex 10 milligram (mg) a total of 29 tablets, sitting on top of a medication cart. The Inspector requested that RPN #104 call RPN #109 to return to the medication room.

During an interview with RPN #109, they reported that they removed the package of Statex from the locked box to remove a sticker from the package and had forgotten to place it back into the locked box. RPN #109 confirmed that they should not have left the controlled substance unlocked, sitting on top of the medication cart.

A record review of the home's policy "Narcotics and Controlled Drugs - #PH-12-01" revised March 2015, indicated that narcotics and controlled drugs had to be stored in a double-locked cupboard/cabinet at all times.

During an interview with the Nursing Manager #106, they confirmed that all controlled substances had to be double-locked and Statex should not have been left on top of the cart in the medication room. [s. 129. (1) (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 controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #4: 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).

**s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).**

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the home's Infection Control program, specifically the hand hygiene program.

A review of the home's policy titled, "Hand-Washing-#IC 04-05" revised August 2014, indicated that hand hygiene was the single most important way to prevent the spread of infection. Hand hygiene was the responsibility of all individuals involved in health care. Hand hygiene was referred as the removing of micro-organisms using two methods, washing with soap and water or using alcohol based hand rub. Hand hygiene was to be performed preparing, serving, handling or eating food.

On a day in June 2018, during lunch service in the dining room, Inspector #617 observed PSW #101 not clean their hands prior to serving desserts and food to residents. The Inspector observed PSW #101 feed a resident wearing blue gloves after which they scraped off left over food from the dish into the garbage can and placed the dirty dish and utensils into the dirty dish container on a cart. Immediately after that, while wearing the same blue gloves, the PSW picked up three desserts off of the counter and had served them to three residents seated at two different tables. Immediately after that, while wearing the same blue gloves, the PSW was observed to have picked up half of a sandwich that was sitting on the dining room table in front of a resident and placed it in the resident's hand. The resident then placed the sandwich into their mouth. At one point the PSW was observed to have taken off the blue gloves, dispose of them into the garbage, not wash their hands and continued to take dirty plates off of several resident tables and then served desserts without cleaning their hands.

On another day in June 2018, between 1145 hours (hrs) and 1240 hrs, Inspector #617 observed lunch service in the main dining room. There were 21 residents seated at several dining room tables for the service and three staff assisting the residents. During the service the Inspector observed RPN #104 wearing blue gloves while taking dirty dishes from the resident's tables, clean them off into the garbage and then immediately serve desserts without taking off their gloves, or washing their hands. The Inspector observed PSW #102 and PSW #100 clean dirty plates taken from trays and tables into the garbage, and serve desserts to the residents seated at the tables, without washing their hands prior to serving the food.

The Inspector observed that the dining room had a sink for hand washing located at one end of the room; there was no hand sanitizer station available inside the dining room.

In an interview with RPN #104, PSW #102 and PSW #100, they reported that the home had a hand hygiene program in which they were trained. All three staff confirmed to the Inspector that they were to wash their hands prior to serving food and were not following the program when serving desserts to residents after handling dirty dishes and not washing their hands prior.

In an interview with Nurse Manager #106 they confirmed that staff were expected to wash their hands prior to serving food to the residents after handling dirty dishes as per the home's hand hygiene program. [s. 229. (4)]

2. The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored and that the symptoms were recorded.

Resident #007 was identified as having had a specific infection through their Minimum Data Set (MDS) assessment.

Inspector #577 reviewed the physician order's dated March 2018, which identified that resident #007 was prescribed medication treatments for their symptoms.

A record review of the progress notes dated March 2018, indicated that the resident was placed on special precautions for their symptoms. A review of the home's 'Respiratory Outbreak Line Listing Form', indicated that the resident had the onset of symptoms in March 2018, and was placed on special precautions; their specific symptoms were listed and an antibiotic was started.



The Inspector further determined through a review of the progress notes that there were six 12 hour shifts in March 2018, that did not have documentation for the monitoring of their symptoms:

During an interview with RPN #114, they reported that staff were required to document the residents' symptoms every shift in the progress notes.

During an interview with Nurse Manager #106, together with Inspector #577, reviewed the progress notes during the time of resident #007's specific infection. Nurse Manager #106 confirmed that six shifts did not have documentation for symptoms. They further confirmed that symptoms were to be monitored every shift and documented in the progress notes. [s. 229. (5) (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 on every shift, the symptoms are recorded and that immediate action is taken as required; and all staff participate in the implementation of the home's Infection Control program, specifically the hand hygiene program, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :



1. The licensee has failed to ensure the advice of the Residents' Council and the Family Council, if any, was sought out, in the developing and carrying out the resident satisfaction survey.

In an interview with the Nurse Manager #106, they reported to Inspector #617 that the home had conducted Resident Council meetings every three months with the help of the council assistant, Recreation/Volunteer Coordinator #111.

Inspector #617 observed that the results of the 2017 resident satisfaction survey were posted on the bulletin board by the entrance to the residential area.

In an interview with Nurse Manager #106 they reported that the resident satisfaction survey was conducted in December 2017.

A review of the Resident Council meeting minutes indicated that the 2017 resident satisfaction survey results were reviewed at the meeting held on January 23, 2018.

A review of the Resident Council meeting minutes that the home had conducted over the past year revealed that the home did not seek out the advice of the council for the development and follow through of the resident satisfaction survey.

In an interview with Nurse Manager #106, they confirmed that over the past year the home had not sought out the resident council's advice on the developing or carrying out of the resident satisfaction survey. [s. 85. (3)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).



Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of the incident, a fall with fracture where the resident was taken to the hospital.

A Critical Incident System (CIS) report was received by the Director in June 2018, concerning resident #008 who had fallen, suffered a significant injury and was transported to a hospital.

A review of the progress notes dated on a day in June 2018, indicated that resident #008 had fallen on that day, was transported to a hospital and was diagnosed with a significant injury.

A review of the home's policy "Critical Incident Events - #10-04 LTC" revised July 2014, indicated that an incident that caused an injury to a resident for which the resident was taken to the hospital and that resulted in a significant change in the resident's health condition, was to be reported to the MOHLTC as a critical incident no later than one business day after the incident.

Inspector #577 spoke with Nursing Manager #106, who reported that they thought the Critical Incident System report was submitted to the Ministry Of Health & Long-term Care but had actually 'saved' it within the system, instead of submitting. They further confirmed that it had been reported late, and not within 1 business day. [s. 107. (3) 4.]

Issued on this 28th day of June, 2018

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



**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 sous la
Loi de 2007 sur les foyers de
soins de longue durée**

Original report signed by the inspector.



Ministry of Health and
Long-Term Care

Ministère de la Santé et
des Soins de longue durée

Order(s) of the Inspector

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) : DEBBIE WARPULA (577), MELISSA HAMILTON (693),
SHEILA CLARK (617)

Inspection No. /

No de l'inspection : 2018_633577_0008

Log No. /

No de registre : 011618-18

Type of Inspection /

Genre d'inspection: Resident Quality Inspection

Report Date(s) /

Date(s) du Rapport : Jun 27, 2018

Licensee /

Titulaire de permis : Atikokan General Hospital
120 Dorothy Street, ATIKOKAN, ON, P0T-1C0

LTC Home /

Foyer de SLD : Atikokan General Hospital
120 Dorothy Street, ATIKOKAN, ON, P0T-1C0

Name of Administrator /

**Nom de l'administratrice
ou de l'administrateur :** Doug Moynihan

To Atikokan General Hospital, you are hereby required to comply with the following
order(s) by the date(s) set out below:



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 # /

Ordre no : 001

Order Type /

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 134. Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Order / Ordre :

The licensee must be in compliance with O. Reg. 134. Specifically the licensee must;

a) ensure that every resident has a quarterly documented reassessment of their drug regime, that is completed and signed by the physician by the authorization date listed on the Three Month Medication Review Form.

Grounds / Motifs :

1. The licensee has failed to ensure that there was, at least quarterly, a documented reassessment of each resident's drug regime.

On June 20, 2018, Inspector #577 conducted a record review of resident #010's physician's orders, prior to the observation of a medication pass. Inspector #577 identified that resident #010 did not have a current quarterly reassessment of their drug regime. A review of the previous quarterly medication review was signed by the physician on a particular day in March 2018, and the authorization period was from March 1, to May 31, 2018. The current quarterly medication review with an authorization period dated June 1, 2018-August 31, 2018, had not been signed by the physician. A review of the Electronic Medication



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*

Administration Record (MAR) for resident #010 confirmed that staff had been administering resident #010's prescribed medication from June 1-20, 2018.

A review of the pharmacy provider medication policy "Prescriber Medication Orders - #2.2" revised January 17, 2017, indicated that each resident would have their medication(s) reviewed by the prescriber every three months; the review would be done via the Three Month Medication Review Form and a copy of the completed form would serve as the prescription for the resident's medication for three months.

A review of the pharmacy provider medication policy "Three Month Medication Review Check - #2.14" revised March 2017, indicated that each resident's medication orders were to be reviewed by the attending physician at least every 90 days; medication reviews served as prescriptions for the resident's medication during the three month duration indicated on the review.

A review of the unsigned quarterly medication reviews with an authorization period dated June 1, 2018, to August 31, 2018, indicated that a total of 24 residents were missing physician signatures authorizing the administration of the residents' medications for the period of June 1, to August 31, 2018. In total, 92 per cent of the residents in the home, did not have a current and valid prescription for administration of their medications that had been administered since June 1, 2018, and were currently being administered.

During an interview with Clinical Consultant Pharmacist #112, for the pharmacy provider, they reported that the three month medication reviews served as prescriptions and were considered 'expired' past their authorization date.

During an interview with the Chief Nursing Officer (CNO) #113, they reported that it was the expectation of the home that the physicians completed their three month medication review by the required time and it was a scheduling issue with the physicians.

During an interview with Nurse Manager #106, they reported that their process was to obtain a physician review and signature of the resident's quarterly medication review every quarter and were considered active orders until the physician reviewed and signed the next review. They confirmed that 24/26 or 92% of the residents, had expired authorization for the administration of the residents' medications for the period of June 1, to August 31, 2018. [s. 134. (c)]



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

Order(s) of the Inspector

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

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

Ordre(s) de l'inspecteur

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

The decision to issue a Compliance Order (CO) was based on the severity which was potential for actual harm, the scope was widespread affecting 24 residents (92%), and on-going non compliance with unrelated non-compliance. (577)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Jul 13, 2018



**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

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



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

Order(s) of the Inspector

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

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

Ordre(s) de l'inspecteur

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

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
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.



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

Order(s) of the Inspector

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

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

Ordre(s) de l'inspecteur

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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



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

Order(s) of the Inspector

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

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

Ordre(s) de l'inspecteur

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

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 27th day of June, 2018

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



**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*

Name of Inspector /

Debbie Warpula

Nom de l'inspecteur :

Service Area Office /

Bureau régional de services : Sudbury Service Area Office