Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
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Amended Public Copy/Copie modifiée 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
Jul 30, 2019	2018_539120_0050 (A2)	003960-18, 003961-18, 003963-18, 003964-18	Follow up

Licensee/Titulaire de permis

Blackadar Continuing Care Centre Inc.
101 Creighton Road DUNDAS ON L9H 3B7

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

Blackadar Continuing Care Centre
101 Creighton Road DUNDAS ON L9H 3B7

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

Amended by BERNADETTE SUSNIK (120) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The due date for Compliance Order #001 is being extended to October 31, 2019, from August 1, 2019.

Issued on this 30th day of July, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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Amended Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): November 21 and 22, 2018

A Resident Quality Inspection (2017-555506-0027) was previously conducted in December 2017, and compliance orders #001, #002, #004 and #005 were issued in February 2018. The compliance orders related to housekeeping services, bed safety, safe resident transfers and availability of regularly employed registered nurses on duty.

During the course of the inspection, the inspector(s) spoke with Administrator, Environmental Services Supervisor, registered staff, maintenance person, housekeepers, personal support workers and residents.

During the course of the inspection, the inspector toured the home, observed resident bed systems, resident lift equipment, reviewed policies and procedures relating to bed safety and clinical assessments, housekeeping cleaning schedules and procedures, educational materials and staff attendance records, registered nursing work schedules and resident clinical records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Falls Prevention
Safe and Secure Home
Sufficient Staffing

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

4 WN(s)
3 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #004	2017_555506_0027	120
O.Reg 79/10 s. 36.	CO #002	2017_555506_0027	120
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #001	2017_555506_0027	120
O.Reg 79/10 s. 87. (2)	CO #005	2017_555506_0027	120

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. 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 :

(A1)
1. The licensee failed to ensure that furnishings and the home were maintained in a good state of repair.

i) A tour of the home was conducted and the majority of the aluminum slider-type windows located throughout the home were not maintained to ensure that they could be latched, closed properly or adequately sealed to keep out drafts. The identified windows were not tight-fitting when closed due to the complete deterioration of the felt seals that once existed around the perimeter of the sliding panes. The windows rattled in the wind and permitted air drafts to enter the room. The aluminum trim around the perimeter of many of the windows between the trim and the wall had gaps directly to the outside. The administrator acknowledged that they did not have any plans in place to replace the windows. Records completed by a maintenance person in April 2018, identified the need to seal windows and to repair the latches in but not limited to three of the windows observed by the inspector to be in poor condition. During the inspection, when the the Environmental Services Supervisor (ESS) was asked to provide the plans to address the audit results from April 2018, a plan or schedule had not been developed.

ii) Over bed tables in two identified rooms were in a poor state of repair. The tables were comprised of laminated press board tops on metal frames. The laminate along the edges of the tops deteriorated or peeled away, exposing the sharp press board underneath. In this state, they could not be adequately cleaned and were a potential safety hazard for skin tears.. The metal frames were also observed to be rusty. Records completed by a maintenance person in April 2018, identified chipped tables in one of the identified rooms. During the inspection, the ESS was asked to provide the plans to address the audit results from April 2018, but a plan or schedule had not been developed.

iii) An area of the ceiling and wall in an identified tub room were not in a good state of repair. Old water stains and peeling paint was observed, along with several holes. According to the ESS, they struggled with a history of leaks from above and until they could determine the source of the leak, repairs had not been made. The tub room also had missing wall tiles in the area where an unused domestic tub had been removed. The ESS did not have any specific dates as to when the area would be tiled.

While in an identified room during the inspection, peeling paint and signs of past water intrusion (mineral deposits) were observed along the ceiling near the window. Occupants of the room reported water dripping down from the ceiling in the spring and summer of 2018. According to the Administrator, although the roof

had been repaired a few years prior, water continued to enter the building during heavy rain. The Administrator had a theory and was trying to determine the best course of action to address the breach on the exterior of the building. No scheduled repair was in place for the tub room ceiling and wall or the ceiling in the identified resident room and no formal plan was in place for repairs to the exterior of the building.

The licensee failed to maintain furnishings and the home in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

An inspection (2017-555506-0027) was previously conducted in December 2017, and compliance order #004 was issued in February 2018, with the following requirements:

1. Amend the home's existing "Bed Rail Entrapment and Risk Assessment" form related to resident clinical assessments and the use of bed rails to include additional relevant questions and guidance related to bed safety hazards related to:
a) the resident while sleeping for a specified period of time in their bed system with one or more bed rails applied, that establishes their ability to understand and independently use their bed rail(s) or any other accessory or bed component that has been deemed necessary; and
b) whether the resident displayed any sleep related behaviours that could have increased their chances of becoming injured, suspended, entangled or entrapped, and
c) whether the alternatives that were trialled prior to using one or more bed rails were effective or not during a specified period and document the outcome.
2. Develop or acquire fact sheets or pamphlets that can be made available for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario. The hand out or fact sheet shall include information regarding the assessment process of residents once admitted to the home related to bed rail use, the risk factors that are considered high risk for bed system injury, suspension, entanglement or entrapment, the benefits versus the risks of bed rail use, alternatives to bed rail use, the role of the Substitute Decision Maker and consents, how bed systems are monitored to ensure they do not pose a safety risk for residents, and the contact information for Health Canada, Medical Devices Bureau for additional information and any bed system related injury, entrapment, entanglement or suspension event.

3. Re-evaluate all beds to ensure that all mattresses are appropriately sized for the bed frame and are matched to the bed frame either by serial number or other unique identifier. If mattresses cannot be acquired to fit between the existing mattress keepers (for those beds with plastic keepers) or the mattress will not stay within the mattress keepers once placed, replace the plastic keepers with a

different style of mattress keeper that will more easily accommodate the mattress.

4. Amend the current "Resident Bedrail Risk Assessment and Use" policy to include additional and relevant information noted in the prevailing practices identified as the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings", U.S. F.D.A, April 2003) and at a minimum the policy shall include;
a) details of the process of assessing residents upon admission and when a change in the resident's condition has been identified to monitor residents for risks associated with bed rail use and the use of any bed related attachments/accessories on an on-going basis; and
b) guidance for the assessors in being able to make clear decisions based on the data acquired by the various team members and to conclude and document the risk versus the benefits of the application of one or more bed rails for residents; and
c) alternatives that are available specifically for the replacement of bed rails and the process of trialling the alternatives and documenting their use; and
d) what interventions are available to mitigate any identified bed safety entrapment or injury risks should a resident benefit more from the use of one or more bed rail(s)(i.e. wedges, bolsters, bed rail pads) vs the risk; and
e) the role of the SDM and/or resident in selecting the appropriate device for bed mobility and transfers; and
f) the role of and responsibilities of personal support workers with respect to observing residents in bed related to their bed systems (which includes bed rails, bed frame, accessories, mattresses, bed remote controls) and associated safety hazards;
g) the various bed system malfunctions that need to be monitored for, by which staff members and how reported to maintenance for follow up.

5. Upon completion of the amendments to the assessment form and procedures, all direct care staff (RNs, RPNs, PSWs) shall receive face to face instruction. The training shall at a minimum include the following:
a) where the zones of entrapment are on each type of bed where there may be more than one style of bed rail applied; and
b) how a resident can become entrapped, entangled, suspended (depending on type of rail) and injured on the type of bed system they were provided; and
c) how to identify loose bed rails and ill-fitting mattresses and how to ensure mattresses remain in the bed keepers and who will be contacted when problems are identified; and

d) the contents of the procedures and associated forms shall be reviewed and a record shall be kept of those who participated and the dates attended.

6. Re-assess all residents who have bed rails in place including resident #005, #017, #044, #045 and #046.

The compliance date to complete the above requirements was August 2018. The licensee completed requirements #1, 2, 3, 5, 6 but failed to complete requirement #4 d, e, f, g.

The Director of Care provided a copy of their most current policy related to bed safety entitled "Bed Rail Minimization and Risk Reduction" RC-08-01-09, dated April 2017. Upon review of the policy, the following information was missing:

d) The interventions that were available to staff to use to mitigate any identified bed safety entrapment or injury risks should a resident benefit more from the use of one or more bed rail(s)(i.e. wedges, bolsters, bed rail pads) vs the risk.
e) The role of the SDM and/or resident in selecting the appropriate device for bed mobility and transfers (other than obtaining their consent).
f) The role of and responsibilities of personal support workers with respect to observing residents in bed related to their bed systems (which includes bed rails, bed frame, accessories, mattresses, bed remote controls) and associated safety hazards.
g) The various bed system malfunctions that need to be monitored for, by which staff members and how reported to maintenance for follow up.

According to the licensee, the policies could not be changed or amended as the policies were developed and amended by their management company. In December 2018, a representative from the management company identified that the bed safety policies were being redeveloped and were in draft mode. Unfortunately, the policies had not been implemented by the due date of August 2018 and remained outstanding during the time of inspection.

The licensee therefore failed to ensure that where bed rails were used, that the resident was assessed in accordance with prevailing practices to minimize risk to the resident. [s. 15. (1) (a)]

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 where bed rails are used, that the resident is assessed in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that safe transferring and positioning devices or techniques were used when assisting residents.

An inspection (2017-555506-0027) was previously conducted in December 2017, and compliance order #002 was issued in February 2018, with the following requirements:

1. The licensee will ensure that staff use safe transferring and positioning devices or techniques when assisting residents.
2. The licensee will provide education and training to all staff involved in the transfer and positioning of residents. Attendance records are to be maintained related to this training.
3. The licensee will develop and implement a system for monitoring staff's performance in complying with directions identified in residents plans of care for transferring and positioning

The compliance date to complete the above requirements was April 2018. The licensee completed requirements #1 and #2 but failed to complete requirement #3.

During the inspection, the administrator and Director of Care acknowledged that a system to monitor staff performance in complying with the plan of care for each resident requiring physical assistance with transferring and positioning was not implemented. An audit tool with specific questions was developed to determine if personal support workers performed transfer and positioning techniques safely, and if using mechanical equipment, in accordance with manufacturer's directions. The audit tool was not implemented.

The licensee failed to develop and implement a system for monitoring staff's performance in complying with directions identified in residents' plans of care for safe transferring and positioning. [s. 36.]

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 safe transferring and positioning devices or techniques are used when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. As part of the organized program of housekeeping under clause 15(1)(a) of the Act, the licensee failed to ensure that procedures were implemented for cleaning of the home, including floors and windows.

An inspection (2017-555506-0027) was previously conducted in December 2017, and compliance order #005 was issued in February 2018, with the following requirements:

1. Cleaning procedures that include how every resident room and ensuite washroom will be thoroughly cleaned (daily clean and deep clean) to ensure that dust and visible matter is removed from floors, furnishings, walls (including baseboards), heaters, window sills, doors, ceiling fixtures and vents, including what solutions and supplies/equipment are to be used; and
2. A schedule that includes adequate time for housekeeping staff to clean each type of room (whether a daily clean or a deep clean) in accordance with the

cleaning procedures; and
3. Procedures that include how the kitchen walls, floors, ceilings, exhaust hood, fixed equipment (tables, oven, steamer, fridges), steam tables, three compartment sink, dishwasher, dishwasher trays, floor mats, drains, shelving are to be cleaned including what type of solutions and supplies/equipment are to be used; and
4. How often and how each resident room and kitchen will be evaluated to ensure the cleaning standards have been met.
5. A floor stripping and re-waxing schedule for all areas of the home that have wax flooring and that includes who will conduct the stripping and re-waxing.
6. A buffing schedule for all areas of the home that have wax flooring and who will conduct the buffing.
7. All dietary aides shall have input in developing the kitchen cleaning schedules and procedures and all housekeepers shall have input in developing the resident room/washroom cleaning schedules and procedures.

The compliance date to complete the above requirements was August 2018. The licensee completed requirements #1-4 and #7, but failed to implement #1, #5 and #6.

During the inspection, a tour of the home was conducted to determine the level of sanitation achieved in the home. Heavy amounts of dust and other debris was observed between the two layers of sliding windows in various common areas and rooms throughout the first and second floors. Housekeeper #006, when asked if windows were cleaned routinely, reported that the interior glass and trim were spot cleaned but not the areas between the panes of sliding windows. According to the housekeeping aide job routine, dated March 2018, windows were to be spot cleaned and annually, the windows were to be washed inside. The housekeeper said that the windows were usually deep cleaned by an external company at least once a year. The administrator acknowledged that the windows were not thoroughly cleaned in 2018.

The flooring throughout resident rooms and in dining rooms were observed to be marginally cleaner from the previous inspection and did not appear to have been sealed or buffed. The Environmental Services Supervisor acknowledged that the floors were not sealed (and therefore not buffed) due to the hot weather conditions throughout the summer months, and had delayed the project. A schedule to begin sealing the floors at the time of inspection had not been implemented.

The licensee failed to implement their procedures related to floor care and window cleaning. [s. 87. (2) (a)]

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 procedures are implemented for cleaning of the home, including floors and windows, to be implemented voluntarily.

Issued on this 30th day of July, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by BERNADETTE SUSNIK (120) - (A2)
Inspection No. / No de l'inspection :	2018_539120_0050 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	003960-18, 003961-18, 003963-18, 003964-18 (A2)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Jul 30, 2019(A2)
Licensee / Titulaire de permis :	Blackadar Continuing Care Centre Inc. 101 Creighton Road, DUNDAS, ON, L9H-3B7
LTC Home / Foyer de SLD :	Blackadar Continuing Care Centre 101 Creighton Road, DUNDAS, ON, L9H-3B7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shelly Desgagne

To Blackadar Continuing Care Centre Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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).

Order / Ordre :

(A1)
The licensee must be compliant with s.15(2) of the LTCHA, 2007.

Specifically, the licensee shall;

1. Conduct an audit of all windows, furnishings, ceilings and walls in the home by January 30, 2019. The results of the audit shall be documented, along with specified target dates to address the condition of the windows, furnishings and surfaces and identify who will be responsible for the tasks.
2. The licensee shall develop a plan to address the condition of the furniture, windows and surfaces and submit it to HamiltonSAO.MOH@ontario.ca attention Bernadette Susnik by February 28, 2019.

The target dates for completing the work shall be implemented by August 1, 2019. Should any identified work require additional time to complete, specify the reason in the plan.

Grounds / Motifs :

1. The licensee failed to ensure that furnishings and the home were maintained in a good state of repair.

i) A tour of the home was conducted and the majority of the aluminum slider-type windows located throughout the home were not maintained to ensure that they could be latched, closed properly or adequately sealed to keep out drafts. The identified windows were not tight-fitting when closed due to the complete deterioration of the felt seals that once existed around the perimeter of the sliding panes. The windows rattled in the wind and permitted air drafts to enter the room. The aluminum trim around the perimeter of many of the windows between the trim and the wall had gaps directly to the outside. The administrator acknowledged that they did not have any plans in place to replace the windows. Records completed by a maintenance person in April 2018, identified the need to seal windows and to repair the latches in but not limited to three of the windows observed by the inspector to be in poor condition. During the inspection, when the the Environmental Services Supervisor (ESS) was asked to provide the plans to address the audit results from April 2018, a plan or schedule had not been developed.

ii) Over bed tables in two identified rooms were in a poor state of repair. The tables were comprised of laminated press board tops on metal frames. The laminate along the edges of the tops deteriorated or peeled away, exposing the sharp press board underneath. In this state, they could not be adequately cleaned and were a potential safety hazard for skin tears.. The metal frames were also observed to be rusty. Records completed by a maintenance person in April 2018, identified chipped tables in one of the identified rooms. During the inspection, the ESS was asked to provide the plans to address the audit results from April 2018, but a plan or schedule had not been developed.

iii) An area of the ceiling and wall in an identified tub room were not in a good state of repair. Old water stains and peeling paint was observed, along with several holes. According to the ESS, they struggled with a history of leaks from above and until they could determine the source of the leak, repairs had not been made. The tub room also had missing wall tiles in the area where an unused domestic tub had been removed. The ESS did not have any specific dates as to when the area would be tiled.

While in an identified room during the inspection, peeling paint and signs of past water intrusion (mineral deposits) were observed along the ceiling near the window. The occupants of the room reported water dripping down from the ceiling in the spring and summer of 2018. According to the Administrator, although the roof had

been repaired a few years prior, water continued to enter the building during heavy rain. The Administrator had a theory and was trying to determine the best course of action to address the breach on the exterior of the building. No scheduled repair was in place for the tub room ceiling and wall or the ceiling in the identified resident room and no formal plan was in place for repairs to the exterior of the building.

The licensee failed to maintain furnishings and the home in a good state of repair.

This compliance order (CO) is based upon the above non-compliance and three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. The severity is 2 (potential harm), the scope is 3 or widespread and the compliance history is 3 (1 or more related non-compliance in the last 36 months). (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2019(A2)

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

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:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 30th day of July, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by BERNADETTE SUSNIK (120) - (A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Service Area Office / Bureau régional de services : Hamilton Service Area Office