Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 6, 2019	2019_655679_0028	006153-19, 006582-19, 010255-19, 015530-19, 017919-19, 020201-19	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

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

MICHELLE BERARDI (679), DAVID SCHAEFER (757), KEARA CRONIN (759), LAUREN TENHUNEN (196), MELISSA HAMILTON (693), STEVEN NACCARATO (744)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 4-8, 2019.

The following intakes were inspected upon during this Critical Incident System (CIS) Inspection:

- Five intakes submitted to the Director for resident falls; and,

- One intake submitted to the Director for alleged staff to resident abuse.

PLEASE NOTE: A Compliance Order (CO) related to s. 6. (7) of the Long-Term Care Home's Act, 2007, was identified in this inspection and has been issued in Inspection Report #2019_655679_0030, which was conducted concurrently with this inspection.

A Complaint Inspection (2019_655679_0029) and a Follow Up Inspection (2019_655679_0030) were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Acting Assistant Director of Care (AADOC), Registered Nurse (RN) Supervisor, Restorative Care Registered Practical Nurse (RPN), RNs, RPNs, Resident Assessment Instrument (RAI) Coordinator Backup, Housekeeping Aides, Personal Support Workers (PSWs), residents and families.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, complaint records, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

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

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003, #004, #005, and #011 have been protected from abuse by anyone.

A Critical Incident (CI) report was submitted to the Director on a specified date, indicating that there were separate incidents of alleged staff to resident abuse.

A) Inspector #759 reviewed the CI report that was submitted to the Director. It indicated that RPN #103 witnessed PSW #102 allegedly abusing residents #003, #004 and #005 on separate occasions.

During an interview with PSW #104, they indicated that if they witnessed or were informed of an incident that would be considered abuse, they would report it to their supervisor or the nurse in charge.

Inspectors #759 and #679 interviewed RPN #103, who indicated that if they witnessed anything worrisome it was their duty to report to their supervisor or the Director Of Care (DOC). RPN #103 confirmed that they witnessed the incidents between PSW #102 and residents #003, #004, and #005. When asked by Inspector #759 if they reported these incidents immediately, they indicated that they reported the last two incidents right away and had not reported the first incident immediately. RPN #103 indicated that they were disciplined for not reporting and completed additional education.

Inspector #759 reviewed a specified document which outlined an interview between the previous Director of Clinical Care #123 and RPN #103. When RPN #103 was asked by the previous Director of Clinical Care #123 why they had not reported the allegations at the time of the incidents, the RPN #103 stated a specified reason.

Inspector #759 reviewed the policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting RC-02-01-01" last revised June 2019. It indicated that "anyone who witnesses or suspects abuse or neglect of a resident by another resident, staff, or other person must report the incident. At minimum, any individual who witnesses or suspects abuse or neglect of a resident must notify management immediately".

During an interview with Inspectors #759 and #679, the DOC indicated that they expected staff to report any suspected or actual abuse immediately to their supervisors, the DOC, or the Administrator. The DOC further indicated that based on the training that RPN #103 had received they should have reported the incidents immediately.

During an interview with the Administrator, they identified that they recalled this CI report, as there were separate incidents reported at once. The Administrator further indicated that they would have expected RPN #103 to report the incidents immediately.

B) During an interview with RPN #103, they revealed additional incidents of potential staff to resident abuse. RPN #103 further indicated that they had not reported the incident that occurred with resident #011 for a specified reason.

During an interview with the DOC, they indicated that based on the training and retraining of RPN #103, that both incidents referenced above should have been reported immediately to the supervisor. The DOC also indicated that they would submit a CI report and follow up with RPN #103.

On November 12, 2019, Inspector #759 reviewed the Ministry of Long-Term Care's online reporting portal and did not identify any CI reports relating to the above noted incidents.

C) Inspector #759 reviewed the policy titled "Zero Tolerance of Resident Abuse and Neglect Program RC-02-01-01" last updated June 2019. It indicated that "any form of abuse or neglect by any person will not be tolerated" and that "there is a zero tolerance for abuse".

Inspector #759 reviewed a specified document. The document indicated that RPN #103 was in violation of the following policies: Zero Tolerance for Abuse and Neglect, Failure to Report Immediately, Commitment to Resident-Centered Care and Resident's Bill of Rights.

Inspector #759 reviewed a specified document. The document indicated that PSW #102 was in violation of the following policies: Zero Tolerance for Abuse and Neglect, Commitment to Resident-Centered Care, Resident's Bill of Rights.

During an interview with the DOC, they indicated that they believed these incidents occurred as it was reported, and one resident was able to identify PSW #102.

The licensee has failed to ensure that residents #003, #004, #005, and #011, had been protected from abuse by anyone. [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A CI report was submitted to the Director on a specified date, related to a fall of resident #006 which resulted in an injury.

A review of resident #006's most recent Minimum Data Set (MDS) assessment indicated that the resident required a specific level of mobility assistance from staff.

Inspector #744 reviewed resident #006's current care plan which indicated that the resident required a different level of mobility assistance from staff.

In an interview with Inspector #744, RN #122 indicated that resident #006 currently required a specified level of assistance from staff. RN #122 further stated that the care plan was unclear and had not represented the resident's current mobility status.

Inspector #744 interviewed the DOC who stated that they had confirmed the current mobility status with resident #006's RN and that the appropriate changes would be made to make the care plan more clear. [s. 6. (1) (c)]

2. The licensee has failed to ensure that resident #007's plan of care was reviewed and revised when the resident's care needs changed.

The home submitted a CI report to the Director, which stated that resident #007 had a fall on a specified date. The report indicated that the resident had a number falls over a specified period.

A review of resident #007's electronic fall risk screening tool, indicated that the resident was at a specific level of risk for falls. The tool also indicated specified risk factors for falls.

A review of resident #007's care plan, at the time of the resident's fall, indicated a focus and goals related to falls. The care plan included two specific interventions to mitigate the risk of falls.

During an interview with RN #116, they reviewed the fall risk screening record for resident #007 and stated, "what would have minimized [their] risk [were] the things that [were] in place now" and "things should have been in place prior to that", referring to the resident's fall on a specified date. The RN noted that based on this fall risk assessment, falls prevention interventions should have been in place. The RN noted that the care plan

dated a specified date, in place at the time of the resident's fall, indicated that the resident was ambulating with a specified intervention, which was not current at the time of the fall. The RN added that the home's post-fall assessment which stated to "review and update care plan", was not followed.

During an interview with the DOC, they indicated that based on the electronic fall risk screening record for resident #007, they would expect that the resident would be reassessed, and changes would be made to the plan of care. The DOC stated that the home's falls lead was expected to assess residents when they have a fall and make sure that the care plan was updated. The DOC confirmed that the care plan was not reviewed and updated to put falls prevention interventions in place. [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 ensuring that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and that resident's plans of care are reviewed and revised when the residents care needs change, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act and Regulation required the

licensee of a long-term care home to have, institute or otherwise put in place any strategy, the strategy was complied with.

In accordance with O. Reg 79/10, s. 48 (1) 1. and in reference to O. Reg 79/10 s. 49 (1) the licensee was required to ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury was implemented in the home, that provided strategies to monitor residents.

Specifically, staff did not comply with the home's policy "Falls Prevention and Management Program #RC-15-01-01", last updated August 2019, which required nursing staff to implement the post-fall clinical pathway and "complete an initial physical and neurological assessment" after a resident has fallen. Appendix five of the policy, "Post Fall Clinical Pathway" (last updated August 2019), indicated that staff were to provide a "focused assessment by the first registered staff person on the scene" and to "reassess for possible injury and pain".

The home submitted a CI report to the Director, which stated that resident #007 had a fall on a specified date. The report indicated that a specified amount of time after the fall, the resident showed signs of injury. The resident was transferred to hospital and diagnosed with a specified injury.

During an interview with PSW #128, they stated, "I think the charge nurse didn't do something [they were] supposed to do". The PSW indicated they were going to assist the resident, a specified time period after the resident's fall, and noticed signs of injury. The PSW noted that they then contacted RPN #124 to inform them.

During an interview with RPN #124, they reported that they had completed a post-fall assessment of resident #007, initially after the fall, while the resident remained in a specified mobility aid.

A review of a specified document indicated that during the home's internal investigation into resident #007's fall, RPN #124 indicated that they had not completed a proper assessment on the resident.

During an interview with RN #125, they stated they completed an initial assessment of resident #007, however no documentation of an assessment could be located from this RN, except for a note completed at a specified time on a specified date, which indicated that the resident was assessed before being sent to hospital. The RN indicated they

could not remember if they had documented their assessment. The RN indicated that the resident remained in a specified state during their assessment, and that they had only completed a specified part of the assessment.

During an interview with RN #116, they reported that where a resident was moved post-fall, it was expected that a full head-to-toe assessment and assessment for injury was completed and that a resident could not be assessed for injury while in a specific state.

During an interview with the DOC, they reported that they were notified after the occurrence of resident #007's fall on a specified date. The DOC noted they had inquired with registered staff as to which assessments were done, and was informed that all assessments had been completed. The DOC further added that the resident should not have been assessed in a specified state. The DOC noted that their internal investigation revealed a complete assessment of the resident was not completed for a specified period, when PSWs noted significant changes to resident #007, and the resident was subsequently transferred to bed. The DOC stated that the home's falls prevention policy was not complied with after resident #007's fall. The DOC added that resident #007's health status was compromised as a result of being left for a specified period prior to being fully assessed by the registered staff. [s. 8. (1) (a),s. 8. (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 ensuring that where the Act and Regulation require the licensee of a long-term care home to have, institute or otherwise put in place any strategy, that the strategy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #007 had fallen, that the resident was assessed, and where the circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate instrument specifically designed for falls.

The home submitted a CI report to the Director, which stated that resident #007 had a fall on a specified date, resulting in injury. Please see WN #3 for details.

A review of the home's policy, "Falls Prevention and Management Program - RC-15-01-01", last updated August 2019, indicated that a nurse involved in post fall management was to implement the post-fall clinical pathway which included the post-fall assessment.

The post-fall assessment instrument dated a specified date, indicated that vitals were completed, the resident was at a specified level of risk for falls, and provided a brief description of the post-fall assessment provided, the root cause of the fall, and who was involved in the post-fall huddle. A number of areas in the assessment were left blank.

During an interview with RN #125, they stated that the RPN or RN staff were to complete the post-fall assessment, and that it was to be completed in full. The RN stated that the assessment was to be completed electronically, and this was the only place the post-fall assessment would be documented. The RN stated that when they asked RPN #124 about completed assessments, they replied they had completed all assessments. In an interview with RPN #124, they confirmed that the RPN was to complete the electronic post-fall assessment.

In an interview with RN #116, after reviewing the electronic post-fall assessment completed on a specified date, they stated that the assessment was incomplete, and that all applicable sections should have been filled out.

During an interview with the DOC, they stated that all post-falls assessments, including the electronic post-fall assessment instrument, were expected to be fully completed and documented, and that this documentation was to be completed electronically. The DOC confirmed that there were blank spaces in the post-fall assessment documentation, and that it was not fully completed. [s. 49. (2)]

Issued on this 6th day of December, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	MICHELLE BERARDI (679), DAVID SCHAEFER (757), KEARA CRONIN (759), LAUREN TENHUNEN (196), MELISSA HAMILTON (693), STEVEN NACCARATO (744)
Inspection No. / No de l’inspection :	2019_655679_0028
Log No. / No de registre :	006153-19, 006582-19, 010255-19, 015530-19, 017919-19, 020201-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 6, 2019
Licensee / Titulaire de permis :	CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.) 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Orchard Villa 1955 Valley Farm Road, PICKERING, ON, L1V-3R6

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Jason Gay

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To CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.), you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order / Ordre :

The Licensee must comply with s. 19. (1) of the Long Term Care Home's Act, 2007.

Specifically the licensee shall,
1) Reeducate all direct care staff on the home's policy regarding reporting incidents of suspected or witnessed abuse and;
2) Maintain a written record of the education provided, which should include the date and the names of the staff who completed the education.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #003, #004, #005, and #011 have been protected from abuse by anyone.

A Critical Incident (CI) report was submitted to the Director on a specified date, indicating that there were separate incidents of alleged staff to resident abuse.

A) Inspector #759 reviewed the CI report that was submitted to the Director. It indicated that RPN #103 witnessed PSW #102 allegedly abusing residents #003, #004 and #005 on separate occasions.

During an interview with PSW #104, they indicated that if they witnessed or were informed of an incident that would be considered abuse, they would report it to their supervisor or the nurse in charge.

Inspectors #759 and #679 interviewed RPN #103, who indicated that if they witnessed anything worrisome it was their duty to report to their supervisor or the Director Of Care (DOC). RPN #103 confirmed that they witnessed the incidents

between PSW #102 and residents #003, #004, and #005. When asked by Inspector #759 if they reported these incidents immediately, they indicated that they reported the last two incidents right away and had not reported the first incident immediately. RPN #103 indicated that they were disciplined for not reporting and completed additional education.

Inspector #759 reviewed a specified document which outlined an interview between the previous Director of Clinical Care #123 and RPN #103. When RPN #103 was asked by the previous Director of Clinical Care #123 why they had not reported the allegations at the time of the incidents, the RPN #103 stated a specified reason.

Inspector #759 reviewed the policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting RC-02-01-01" last revised June 2019. It indicated that "anyone who witnesses or suspects abuse or neglect of a resident by another resident, staff, or other person must report the incident. At minimum, any individual who witnesses or suspects abuse or neglect of a resident must notify management immediately".

During an interview with Inspectors #759 and #679, the DOC indicated that they expected staff to report any suspected or actual abuse immediately to their supervisors, the DOC, or the Administrator. The DOC further indicated that based on the training that RPN #103 had received they should have reported the incidents immediately.

During an interview with the Administrator, they identified that they recalled this CI report, as there were separate incidents reported at once. The Administrator further indicated that they would have expected RPN #103 to report the incidents immediately.

B) During an interview with RPN #103, they revealed additional incidents of potential staff to resident abuse. RPN #103 further indicated that they had not reported the incident that occurred with resident #011 for a specified reason.

During an interview with the DOC, they indicated that based on the training and retraining of RPN #103, that both incidents referenced above should have been reported immediately to the supervisor. The DOC also indicated that they would

submit a CI report and follow up with RPN #103.

On November 12, 2019, Inspector #759 reviewed the Ministry of Long-Term Care's online reporting portal and did not identify any CI reports relating to the above noted incidents.

C) Inspector #759 reviewed the policy titled "Zero Tolerance of Resident Abuse and Neglect Program RC-02-01-01" last updated June 2019. It indicated that "any form of abuse or neglect by any person will not be tolerated" and that "there is a zero tolerance for abuse".

Inspector #759 reviewed a specified document. The document indicated that RPN #103 was in violation of the following policies: Zero Tolerance for Abuse and Neglect, Failure to Report Immediately, Commitment to Resident-Centered Care and Resident's Bill of Rights.

Inspector #759 reviewed a specified document. The document indicated that PSW #102 was in violation of the following policies: Zero Tolerance for Abuse and Neglect, Commitment to Resident-Centered Care, Resident's Bill of Rights.

During an interview with the DOC, they indicated that they believed these incidents occurred as it was reported, and one resident was able to identify PSW #102.

The licensee has failed to ensure that residents #003, #004, #005, and #011, had been protected from abuse by anyone.

The severity of this issue was determined to be a level 2 as there was minimal harm to residents #003, #004, #005, and #011. The scope of the issue was a level 2 as it related to two out of three incidents reviewed. The home had a level 3 compliance history as they had previous non-compliance with this section of the LTCHA which included:
- A Compliance Order (CO) issued on March 9, 2017 (2017_360111_0001) with a compliance due date of June 30, 2017.
(759)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Mar 10, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 6th day of December, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Michelle Berardi

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