Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 21, 2020	2019_638542_0027 (A1)	016890-19, 017813-19	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Falconbridge
281 Falconbridge Road SUDBURY ON P3A 5K4

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

Amended by MICHELLE BERARDI (679) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The amendment has been granted to allow the licensee to achieve sustainable compliance.

Issued on this 21st day of January, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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281 Falconbridge Road SUDBURY ON P3A 5K4

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

Amended by MICHELLE BERARDI (679) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 10, 16-18, 21-25, 2019.

Please Note: A Written Notification (WN) related to O. Reg. 79/10, s. 131 (2) was

identified in this inspection and has been issued in Inspection Report 2019_638542_0028, dated November 07, 2019, which was conducted concurrently with this inspection. A Critical Incident Inspection #2019_638542_0029 was also completed concurrently with this inspection.

The following intakes were inspected during this complaint inspection;

One complaint intake was submitted to the Director outlining concerns regarding the home's staffing plan, falls prevention; and,

One complaint intake was submitted to the Director outlining, care related concerns and the home's medication management program and the falls prevention program.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Payroll and Scheduling staff, residents and family members.

The Inspectors conducted daily observations of the provision of care that was provided to the residents, reviewed resident health care records, relevant policies and procedures and staffing schedules.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Sufficient Staffing

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

2 WN(s)
1 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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

1) A complaint was submitted to the Director, regarding care related concerns for resident #003 and the home's staffing plan. The complainant indicated that they had concerns as the home was frequently without a full complement of Personal Support Workers (PSWs).

Inspector #542 was provided with the home's normal staffing plan for all shifts related to the PSW staff. The staffing plan described the number of staff scheduled for each floor.

Inspector #542 received the home's "staffing communication" documents from the Office Manager, which showed how many PSW's each floor was short on all shifts. They indicated that every day they review these documents to ensure accuracy. Inspector #542 reviewed the documents from August 10 – October 18, 2019. The following was documented:

On a specific floor and shift, the home was without a full complement of PSW staff on six specific days in August and four specific days in September.

During the Inspection, the Inspectors identified a number of floors without a full complement of PSW staff.

2) Inspector #542 reviewed resident #009's health care record. Their current care plan indicated their bathing preference. A review of the Point Of Care (POC) charting revealed that on one of their preferred bath days, it was documented that

the “activity did not occur.” A review of the staffing communication document showed that the home was without a full complement of PSW staff on that same day on the unit where resident #009 resided. The staffing communication document identified that the unit was short four PSW staff during the day shift.

Inspector #542 completed a review of resident #005’s health care record. Their current care plan indicated their bathing preference on two specific days during the week. A review of the POC charting was completed and on four different times, there was no documentation regarding the resident's bathing choice. On an additional day, it was documented that the bathing activity did not occur. A review of the home’s staffing communication documents was completed by Inspector #542. It was documented, on all five of the scheduled bathing days for resident #005, the home was without a full complement of PSW staff.

A review of the progress notes for resident #005 from a specific day in August, indicated that they did not receive their bathing choice as there were not enough staff.

Resident #004’s health care record was reviewed by Inspector #542. Their current care plan indicated their bathing preference. It was documented in the progress notes on a specific day in August, that their bathing choice was not provided as the staff did not have the time. On a specific day in September, it was documented that their bathing choice was not provided as the staff did not have the time. A review of the staffing communication documents, identified that they were short six PSWs during the day in August when resident #004 was to receive their scheduled bathing choice.

Resident #010’s health care record was reviewed by Inspector #542. The care plan indicated their bathing preference. A review of the progress notes was conducted and it was documented on a specific day in August, that resident #010 did not receive their bathing choice as there were not enough staff. A review of the POC charting was also conducted. On three specific days in August and one day in September, there was no documentation to indicate that their bathing choice was provided. Inspector #542 reviewed the home’s staffing communication documentation which indicated that on all of four of the above mentioned times, the home was without a full complement of PSW staff.

Inspector #542 reviewed resident #011’s health care record. The care plan indicated their bathing preference. A review of the POC charting was completed

and it was documented on a specific day in August, that their bathing choice did not occur. A review of the home's staffing communication document revealed that they were short four PSWs on that same day and on the same unit where resident #011 resided.

Resident #012's health care record was reviewed and their care plan indicated their bathing preference. On a specific day in August, on the POC charting, nothing was documented and on a different day in August, it was documented that their bathing choice did not occur. In resident #012's progress notes it was documented on one of the days in August, that they did not receive their bathing choice as the staff did not have time. Inspector #542 reviewed the staffing communication documents which showed that the home was without a full complement of PSW staff on the specific days in August when resident #012 was to receive their scheduled bathing choice.

Inspector #542 reviewed resident #013's health care record. The care plan for resident #013 indicated their bathing preference. It was documented in the progress notes on a specific day in October, that their bathing choice was not completed. It was documented in the POC charting that the "activity did not occur" under the bathing heading. According to the "staffing communication" document, the unit where resident #013 resided was short two PSWs on that same day in October.

A review of resident #014's health care record was completed. The care plan indicated resident #014's bathing preference. It was documented in the progress notes on a specific day in October, that their bathing choice was not completed. On the POC charting it was documented that the "activity did not occur." According to the "staffing communication" document, the unit was short two PSWs on the same day in October on the unit where resident #014 resided.

Inspector #542 reviewed resident #015's health care record. The care plan indicated resident #015's bathing preference. It was documented in the progress notes on a specific day in October, that their bathing choice was not completed. There was no documentation in the POC charting on that day in October. According to the "staffing communication" document, the unit where resident #015 resided was short two PSWs the specific day in October.

Inspector #542 reviewed resident #016's health care record. The care plan indicated their bathing preference. It was documented in the progress notes, on a

specific day in October, that they did not receive their bathing choice. It was documented in the POC charting that the "activity did not occur." According to the "staffing communication" document, the unit where resident #016 resided was without a full complement of PSW staff on the specific day in October.

A review of resident #017's health care record was completed. The care plan indicated their bathing preference. It was documented in the progress notes, on a specific day in October, that their bathing choice was missed due to time constraints. In the POC charting it was documented that the "activity did not occur." According to the "staffing communication" document, the unit where resident #017 resided was short four PSWs on that same day in October.

Inspector #542 reviewed resident #018's health care record. The plan of care indicated their bathing preference. It was documented in the progress notes, on a specific day in October, that their bathing choice was missed due to time constraints. In the POC charting, it was documented that the activity did not occur. According to the "staffing communication" document, that the unit where resident #018 resided was without a full complement of PSW staff on the specific day in October.

Inspector #542 interviewed resident #019 who indicated that there were days when they did not see a PSW staff because the home was short PSWs. Resident #019 indicated that they were self-sufficient however there were times when they did not receive their bathing preference because the home was short staffed.

Inspector #542 interviewed PSW #100 who indicated that the home was frequently short PSW staff. PSW #100 further indicated that most often the residents were not receiving their scheduled bathing choice.

Inspector #542 interviewed PSW #102 regarding the home's staffing plan. They indicated that they were frequently without a full complement of PSW staff. Inspector #542 asked how they would document if a resident's bathing choice was not completed. PSW #102 indicated that they would leave the documentation on POC blank.

Inspector #542 interviewed PSW #103 who indicate that the home was always short PSW staff. They further stated that the residents were not receiving adequate care and that their bathing choices were not being completed because of the short staffing. PSW #103 stated that when a resident's bathing choice was

missed they document that the activity was not applicable.

Inspector #542 interviewed PSW #104 who stated that when the resident's bathing choice was missed because of the home not having enough staff, they will push them to the next shift or day, however they often were not completed. They further stated that a specific shift was the worst.

Inspector #542 interviewed PSW #105, who indicated that they would document that the “activity did not occur” or “not applicable” when a resident’s bathing choice was not completed due to staffing.

An interview with RPN #103 was conducted by Inspector #542. RPN #103 stated that the home was always without a full complement of PSW staff. They further elaborated that the residents were not receiving good care and that bathing choices were often not completed. RPN #103 indicated that they try and complete the missed bathing choice on the next shift; however, if they were without a full complement of PSW then they were not completed.

Inspector #542 interviewed RPN #101, who indicated that the home was frequently without a full complement of PSW staff. They further stated that when they worked short PSW staff that everything was late, including, medication administration, meals and nourishments and bathing choices were missed.

An interview was conducted with RPN #108. RPN #108 stated that the home was frequently without a full complement of PSW staff and that all care was rushed. RPN #108 further indicated that the residents’ bathing choices were frequently not completed.

Inspector #542 interviewed RN #109 who stated that the home was frequently working without a full complement of PSWs. RN #109 further indicated that the bathing choices were not completed for the residents when the homes was working short PSWs.

Inspector #542 interviewed the Director of Care (DOC) who indicated that they knew that the home was having difficulty completing the bathing care requirements of residents due to the shortage of PSW staff.

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Inspector #542 completed a review of resident #004, #005, #009, #010, #011, #012, #013, #014, #015, #016, #017 and #018's health care records. It was noted that the residents were not bathed as per their documented preference on their care plan twice a week.

Please refer to WN #1 for further details.

Inspector #542 interviewed the Director of Care (DOC) who indicated that they knew that the home was having difficulty bathing residents due to the shortage of PSW staff. [s. 33. (1)]

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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

Issued on this 21st day of January, 2020 (A1)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by MICHELLE BERARDI (679) - (A1)
Inspection No. / No de l'inspection :	2019_638542_0027 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	016890-19, 017813-19 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 21, 2020(A1)
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Falconbridge 281 Falconbridge Road, SUDBURY, ON, P3A-5K4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Laura Halloran

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Extendicare (Canada) Inc., 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 # / No d'ordre: 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. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8. (1) of the LTCHA.

Specifically, the licensee must ensure that the organized program of personal support services for the home meets the assessed needs of the residents with regards to bathing and showering.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

1) A complaint was submitted to the Director, regarding care related concerns for resident #003 and the home's staffing plan. The complainant indicated that they had concerns as the home was frequently without a full complement of Personal Support Workers (PSWs).

Inspector #542 was provided with the home's normal staffing plan for all shifts related to the PSW staff. The staffing plan described the number of staff scheduled for each floor.

Inspector #542 received the home's "staffing communication" documents from the Office Manager, which showed how many PSW's each floor was short on all shifts.

They indicated that every day they review these documents to ensure accuracy. Inspector #542 reviewed the documents from August 10 – October 18, 2019. The following was documented:

On a specific floor and shift, the home was without a full complement of PSW staff on six specific days in August and four specific days in September.

During the Inspection, the Inspectors identified a number of floors without a full complement of PSW staff.

2) Inspector #542 reviewed resident #009's health care record. Their current care plan indicated their bathing preference. A review of the Point Of Care (POC) charting revealed that on one of their preferred bath days, it was documented that the "activity did not occur." A review of the staffing communication document showed that the home was without a full complement of PSW staff on that same day on the unit where resident #009 resided. The staffing communication document identified that the unit was short four PSW staff during the day shift.

Inspector #542 completed a review of resident #005's health care record. Their current care plan indicated their bathing preference on two specific days during the week. A review of the POC charting was completed and on four different times, there was no documentation regarding the resident's bathing choice. On an additional day, it was documented that the bathing activity did not occur. A review of the home's staffing communication documents was completed by Inspector #542. It was documented, on all five of the scheduled bathing days for resident #005, the home was without a full complement of PSW staff.

A review of the progress notes for resident #005 from a specific day in August, indicated that they did not receive their bathing choice as there were not enough staff.

Resident #004's health care record was reviewed by Inspector #542. Their current care plan indicated their bathing preference. It was documented in the progress notes on a specific day in August, that their bathing choice was not provided as the staff did not have the time. On a specific day in September, it was documented that their bathing choice was not provided as the staff did not have the time. A review of the staffing communication documents, identified that they were short six PSWs

during the day in August when resident #004 was to receive their scheduled bathing choice.

Resident #010's health care record was reviewed by Inspector #542. The care plan indicated their bathing preference. A review of the progress notes was conducted and it was documented on a specific day in August, that resident #010 did not receive their bathing choice as there were not enough staff. A review of the POC charting was also conducted. On three specific days in August and one day in September, there was no documentation to indicate that their bathing choice was provided. Inspector #542 reviewed the home's staffing communication documentation which indicated that on all of four of the above mentioned times, the home was without a full complement of PSW staff.

Inspector #542 reviewed resident #011's health care record. The care plan indicated their bathing preference. A review of the POC charting was completed and it was documented on a specific day in August, that their bathing choice did not occur. A review of the home's staffing communication document revealed that they were short four PSWs on that same day and on the same unit where resident #011 resided.

Resident #012's health care record was reviewed and their care plan indicated their bathing preference. On a specific day in August, on the POC charting, nothing was documented and on a different day in August, it was documented that their bathing choice did not occur. In resident #012's progress notes it was documented on one of the days in August, that they did not receive their bathing choice as the staff did not have time. Inspector #542 reviewed the staffing communication documents which showed that the home was without a full complement of PSW staff on the specific days in August when resident #012 was to receive their scheduled bathing choice.

Inspector #542 reviewed resident #013's health care record. The care plan for resident #013 indicated their bathing preference. It was documented in the progress notes on a specific day in October, that their bathing choice was not completed. It was documented in the POC charting that the "activity did not occur" under the bathing heading. According to the "staffing communication" document, the unit where resident #013 resided was short two PSWs on that same day in October.

A review of resident #014's health care record was completed. The care plan indicated resident #014's bathing preference. It was documented in the progress

notes on a specific day in October, that their bathing choice was not completed. On the POC charting it was documented that the "activity did not occur." According to the "staffing communication" document, the unit was short two PSWs on the same day in October on the unit where resident #014 resided.

Inspector #542 reviewed resident #015's health care record. The care plan indicated resident #015's bathing preference. It was documented in the progress notes on a specific day in October, that their bathing choice was not completed. There was no documentation in the POC charting on that day in October. According to the "staffing communication" document, the unit where resident #015 resided was short two PSWs the specific day in October.

Inspector #542 reviewed resident #016's health care record. The care plan indicated their bathing preference. It was documented in the progress notes, on a specific day in October, that they did not receive their bathing choice. It was documented in the POC charting that the "activity did not occur." According to the "staffing communication" document, the unit where resident #016 resided was without a full complement of PSW staff on the specific day in October.

A review of resident #017's health care record was completed. The care plan indicated their bathing preference. It was documented in the progress notes, on a specific day in October, that their bathing choice was missed due to time constraints. In the POC charting it was documented that the "activity did not occur." According to the "staffing communication" document, the unit where resident #017 resided was short four PSWs on that same day in October.

Inspector #542 reviewed resident #018's health care record. The plan of care indicated their bathing preference. It was documented in the progress notes, on a specific day in October, that their bathing choice was missed due to time constraints. In the POC charting, it was documented that the activity did not occur. According to the "staffing communication" document, that the unit where resident #018 resided was without a full complement of PSW staff on the specific day in October.

Inspector #542 interviewed resident #019 who indicated that there were days when they did not see a PSW staff because the home was short PSWs. Resident #019 indicated that they were self-sufficient however there were times when they did not receive their bathing preference because the home was short staffed.

Inspector #542 interviewed PSW #100 who indicated that the home was frequently short PSW staff. PSW #100 further indicated that most often the residents were not receiving their scheduled bathing choice.

Inspector #542 interviewed PSW #102 regarding the home's staffing plan. They indicated that they were frequently without a full complement of PSW staff. Inspector #542 asked how they would document if a resident's bathing choice was not completed. PSW #102 indicated that they would leave the documentation on POC blank.

Inspector #542 interviewed PSW #103 who indicate that the home was always short PSW staff. They further stated that the residents were not receiving adequate care and that their bathing choices were not being completed because of the short staffing. PSW #103 stated that when a resident's bathing choice was missed they document that the activity was not applicable.

Inspector #542 interviewed PSW #104 who stated that when the resident's bathing choice was missed because of the home not having enough staff, they will push them to the next shift or day, however they often were not completed. They further stated that a specific shift was the worst.

Inspector #542 interviewed PSW #105, who indicated that they would document that the "activity did not occur" or "not applicable" when a resident's bathing choice was not completed due to staffing.

An interview with RPN #103 was conducted by Inspector #542. RPN #103 stated that the home was always without a full complement of PSW staff. They further elaborated that the residents were not receiving good care and that bathing choices were often not completed. RPN #103 indicated that they try and complete the missed bathing choice on the next shift; however, if they were without a full complement of PSW then they were not completed.

Inspector #542 interviewed RPN #101, who indicated that the home was frequently without a full complement of PSW staff. They further stated that when they worked short PSW staff that everything was late, including, medication administration, meals and nourishments and bathing choices were missed.

An interview was conducted with RPN #108. RPN #108 stated that the home was frequently without a full complement of PSW staff and that all care was rushed. RPN #108 further indicated that the residents' bathing choices were frequently not completed.

Inspector #542 interviewed RN #109 who stated that the home was frequently working without a full complement of PSWs. RN #109 further indicated that the bathing choices were not completed for the residents when the homes was working short PSWs.

Inspector #542 interviewed the Director of Care (DOC) who indicated that they knew that the home was having difficulty completing the bathing care requirements of residents due to the shortage of PSW staff.

The decision to issue a Compliance Order (CO) was based on the scope being widespread, the severity level with a minimal harm or minimal risk to the well-being of the residents. In addition, the home's compliance history identified previous non-compliance issued specific to this area of the legislation. The home's history of non-compliance in this of the legislation was as follows;

- A Compliance Order (CO) was issued on February 1, 2019, during inspection #2019_655679_0001 and,

- A Voluntary Plan of Correction (VPC) was issued on June 28, 2018, during inspection #2018_671684_0013.

(542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 07, 2020(A1)

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 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 Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

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RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 21st day of January, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by MICHELLE BERARDI (679) - (A1)

Ontario

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Ministère des Soins de longue durée

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