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

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Public Copy/Copie 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
Dec 1, 2021	2021_864627_0024	012946-21, 014985-21, 015144-21, 015161-21, 015466-21	Complaint

Licensee/Titulaire de permis

Barrie Long Term Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street Midland ON L4R 2E1

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

Roberta Place
503 Essa Road Barrie ON L4N 9E4

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

SYLVIE BYRNES (627), AMY GEAUVREAU (642), TIFFANY BOUCHER (543)

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 25-29 and November 1-5, 2021. Additional off-site activities were completed on November 8-10, 2021.

The following intakes were inspected during this Complaint inspection:

- Four logs related to care concerns; and,
- One log related to alleged neglect from staff to multiple residents.

A Critical Incident System inspection, #2021_864627_0025, was conducted concurrently with this inspection.

A finding of non-compliance, related to section (s.) 24 (1) of the Long-Term Care Homes Act, 2007, identified in Critical Incident System inspection, #2021_864627_0025, was issued in this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Director of Care (Co-DOC), Restorative Care Coordinator, Program Coordinator at the Career College of Health, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Personal Support Assistants (PSAs), families and residents.

The Inspectors conducted daily observations of the provision of care to the residents, reviewed relevant health care records, relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

7 WN(s)
5 VPC(s)
2 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 residents were not neglected by the licensee or staff.

Ontario Regulations 79/10, defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The home's investigation notes and interviews with staff indicated that on a day shift, numerous residents were were found having not received continence care and were improperly groomed, which was an indication that night rounds were not completed. There was no indication of how long the residents remained in this condition. The DOC verified that it was not acceptable to have residents in this condition.

The lack of care and the condition the residents were received in was inconsistent with providing care, services or assistance required for health, safety or well-being and caused actual risk to the residents.

Sources: complaint report, residents' health care records, the home's internal investigation templates and documents, interviews with a PSW, Program Coordinator at the College of Health and the DOC. [543] [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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed within one business day of an incident that caused an injury to residents for which the residents were taken to the hospital, and that resulted in a significant change in the residents' health condition.

a) A resident had three falls that caused injuries for which the resident as taken to the hospital and that resulted in a significant change in the resident's health condition. The DOC stated that the three fall incidents had not been reported to the Director.

The lack of reporting an incident that caused an injury to the resident for which the resident was taken to a hospital and resulted in a significant change to the resident caused no harm to the resident.

Sources: Interviews with DOC and other staff members, record review; progress notes, fall report, home's policy titled; "Resident Rights, Care and Services- Reporting and Complaints". [s. 107. (3) 4.]

b. A resident fell and was sent to the hospital due to an injury which caused a significant change to their health condition. The Administrator and the DOC stated that a critical incident report had not been completed to report the resident's fall.

The lack of reporting an incident that caused an injury to the resident for which the resident was taken to a hospital and resulted in a significant change to the resident caused no harm to the resident.

Sources: Home's policy titled, "Resident Rights, Care and Services- Reporting and Complaints"; progress notes; hospital records, fall investigation notes, interviews with the Administrator, DOC, and other staff. [s. 107. (3) 4.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was reassessed and their plan of care revised when the resident's care needs changed.

a) A resident fell on three separate occasions. The home identified three interventions to mitigate the risk of further falls. The resident's written plan of care had not included the three new interventions. The Restorative Care Coordinator stated that the interventions had been implemented and verbally communicated to front line staff; however, they were not added to the resident's care plan.

The lack of revisions to the resident's plan of care caused an actual risk of harm to the resident as new staff may not have been aware of the interventions.

Sources: Interview with Restorative Care Coordinator and other staff members; record review, post fall assessments, resident's care plan, home's policy titled, "Resident Rights, Care and Services- Required Programs- Falls Prevention and Management", home's policy titled, " Resident's Rights, Care and Services- Plan of Care (Care Planning)".

b) An intervention for one to one staffing, for a resident, was implemented on a specific date. The resident's written care plan was updated more than a month later. The Co-DOC stated that the resident's care plan should have been updated to reflect the one to one staffing when the intervention was first implemented.

The lack of revision of the resident's plan of care when their care needs changed caused minimal risk to the resident.

Sources: Interviews with a Registered Nurse, Co-DOC, record review; Monthly High Intensity Needs Fund (HINF) Claim Form, resident's care plan, home's policy titled, "Resident Rights, Care and Services- Plan of Care (Care Planning)". [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of residents had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Multiple residents were received by the day staff having not received continence care. The Program Coordinator at the Career College of Health stated that they had notified the RN of the incident in the morning, when they became aware of it: however, the Director was not notified of the incident until the following day.

Sources: complaint report, residents' health care records, the home’s internal investigation documents, interviews with a PSW, Program Coordinator at the Career College of Health and the DOC. [s. 24. (1)]

2. The licensee has failed to ensure that when they were informed of an alleged incident of resident to resident abuse, the suspicion and the information upon which it was based was immediately reported to the Director.

A resident caused injury to another resident. The home submitted a CIS report regarding the incident on the following day. The DOC stated the incident should have been reported immediately.

The late reporting of the incident caused no risk to the resident.

Sources: Critical Incident report; the home’s policy titled, “Abuse-Zero Tolerance policy for Resident Abuse and Neglect”; progress notes; Interviews with DOC, and other staff. [642] [s. 24. (1) 2.]

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 a person who has reasonable grounds to suspect tah tany of the following has occurred or may occur shall immediately report the suspicion and the informatio upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm tot he resident;, to be implemented voluntarily.

WN #5: 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 a resident was bathed at a minimum twice a week by the method of their choice.

A resident did not receive a shower on two specific dates. The documentation indicated “not applicable”. According to staff, not applicable would be documented when a bath was not completed due to staffing shortages. The DOC and Co-DOC could not provide documentation to show that the resident’s shower had been given on the two specific dates or made up on a following days.

The missed baths may have impacted the resident's quality of life.

Sources: Interviews with a PSW, RPN, RN, Co-DOC, DOC; record review, the resident’s plan of care, POC “follow up question report” for a two month period, home’s policy titled “Resident Rights Care and Services-Plan of Care”. [s. 33. (1)]

2. A resident did not receive a shower on three specific dates. The documentation indicated “not applicable”. A PSW stated that they could not recall why they had not provided a shower to the resident. Another PSW, Registered Practical Nurse (RPN), and an RN stated that “not applicable” would be documented when a bath was not completed due to staffing shortages. The DOC and Co-DOC could not provide documentation to show that the resident’s shower had been given on the three specific dates or made up on the following days.

The missed baths may have impacted the resident's quality of life.

Sources: Interviews with PSWs, RPN, RN, Co-DOC, DOC; record review, resident’s plan of care, POC “follow up question report” for a two month period, home’s policy titled “Resident Rights Care and Services-Plan of Care”. [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 wwk 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.

WN #6: 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 a resident had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A resident was found on the floor. An RN stated that a post fall assessment was to be completed for every fall that occurred and if the fall was unwitnessed, a head injury routine (HIR) must be completed. The DOC verified that a post fall assessment had not been completed when the resident was found on the floor.

The lack of a post fall assessment caused actual risk to the resident.

Sources: CIS report, complaint report, a resident's health care record, interviews with an RN, the DOC and other staff members and the home's "Falls Prevention and Management Program" . [s. 49. (2)]

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 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, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents' substitute decision-makers (SDMs) , if any, and any other person specified by the residents were notified within 12 hours upon the licensee becoming aware of an alleged incident of neglect of the residents.

Multiple residents were received by the day staff having not received continence care. The CIS report indicated that the residents' SDMs were not notified of the incident.

The lack of notification to the residents' SDMs, of an alleged incident of neglect from staff to multiple residents, prevented the SDMs from being fully informed of the incident and of the steps the home was taking to ensure the residents would be cared for in a manner consistent with their care needs.

Sources: CIS report, complaint report, the home's internal investigation documents, residents' health care records, interviews with the DOC and other staff. [s. 97. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's substitute decision maker, if any, and any other person specified by the resident are notified within 12 hours upon the licensee becoming aware of any alleged, suspected, witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

Issued on this 13th day of December, 2021

[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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	SYLVIE BYRNES (627), AMY GEAUVREAU (642), TIFFANY BOUCHER (543)
Inspection No. / No de l’inspection :	2021_864627_0024
Log No. / No de registre :	012946-21, 014985-21, 015144-21, 015161-21, 015466-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 1, 2021
Licensee / Titulaire de permis :	Barrie Long Term Care Centre Inc. c/o Jarlette Health Services, 711 Yonge Street, Midland, ON, L4R-2E1
LTC Home / Foyer de SLD :	Roberta Place 503 Essa Road, Barrie, ON, L4N-9E4
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Emily Dillman

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

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

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. 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 be compliant with section (s.) 19 (1), of the Long-Term Care Homes Homes Act, 2007.

Specifically, the licensee shall ensure that residents are not neglected and are provided with continence and grooming, in a manner consistent with their needs.

Grounds / Motifs :

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

1. 1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

Ontario Regulations 79/10, defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The home's investigation notes and interviews with staff indicated that on a day shift, numerous residents were were found having not received continence care and were improperly groomed. There was no indication of how long the residents remained in this condition. The DOC verified that it was not acceptable to have residents in this condition.

The lack of care and the condition the residents were received in was inconsistent with providing care, services or assistance required for health, safety or well-being and caused actual risk to the residents.

Sources: complaint report, residents’ health care records, the home’s internal investigation templates and documents, interviews with a PSW, Program Coordinator at the College of Health and the DOC. [543] [s. 19. (1)]

An order was made by taking the following factors into account:
Severity: There was actual risk of harm to the residents who were not provided with continence and personal care.
Scope: The scope of this non-compliance was a pattern as continence and personal care was not provided for eight of thirteen residents, on a resident home unit.
Compliance History: One Compliance Order under the same subsection, was issued to the home in the last 36 months.
(627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Dec 17, 2021

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
3. A missing or unaccounted for controlled substance.
4. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Order / Ordre :

The licensee must be compliant with s. 107 (3) of Ontario Regulation (O.Reg.) 79/10.

Specifically, the licensee shall:
a) Develop and implement a process to ensure that all incidents that cause an injury for which a resident is taken to the hospital and that result in a significant change to the resident's health condition, is reported to the Director no later than one business day.
b) The process shall be documented and included in the home's critical incident reporting policy.

Grounds / Motifs :

1. The licensee has failed to ensure that the Director was informed within one business day of an incident that caused an injury to residents for which the residents were taken to the hospital, and that resulted in a significant change in the residents' health condition.

a) A resident had three falls that caused injuries for which the resident as taken to the hospital and that resulted in a significant change in the resident's health condition. The DOC stated that the three fall incidents had not been reported to the Director.

The lack of reporting an incident that caused an injury to the resident for which the resident was taken to a hospital and resulted in a significant change to the resident caused no harm to the resident.

Sources: Interviews with DOC and other staff members, record review; progress notes, fall report, home's policy titled; "Resident Rights, Care and Services- Reporting and Complaints". [s. 107. (3) 4.] (627)

2. b. A resident fell and was sent to the hospital due to an injury which caused a significant change to their health condition. The Administrator and the DOC stated that a critical incident report had not been completed to report the resident's fall.

The lack of reporting an incident that caused an injury to the resident for which the resident was taken to a hospital and resulted in a significant change to the resident caused no harm to the resident.

Sources: Home's policy titled, "Resident Rights, Care and Services- Reporting and Complaints"; progress notes; hospital records, fall investigation notes, interviews with the Administrator, DOC, and other staff. [s. 107. (3) 4.]

An order was made by taking the following factors into account:
Severity: There was no harm to the residents from the lack of reporting when the residents were taken to a hospital for an incident that resulted in a significant change to the residents' health status.
Scope: The scope of this non-compliance was widespread as four out of five falls for which the resident was sent to the hospital and that resulted in a

significant change to the residents' health status, were not reported to the Director, within one business day. .
Compliance History: In the past 36 months, one written notification was issued to the home related to the same sub-section.
(642)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 14, 2022

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 1st day of December, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sylvie Byrnes

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