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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 19, 2019	2019_773155_0010 (A1)	009749-19	Complaint

Licensee/Titulaire de permis

Corporation of the County of Simcoe
1110 Highway 26 Midhurst ON L9X 1N6

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

Sunset Manor Home for Senior Citizens
49 Raglan Street COLLINGWOOD ON L9Y 4X1

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

Amended by SHARON PERRY (155) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance Order #003 compliance due date extended to October 9, 2019.

Issued on this 19th day of September, 2019 (A1)

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

Original report signed by the inspector.

Ontario

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

Amended by SHARON PERRY (155) - (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): May 29, 31, June 4, 5, 6, 7, 10, 11, 12, and 13, 2019

During this inspection, log 009749-19 a complaint related to an allegation of alleged abuse/neglect was completed.

Tawnie Urbanski, Inspector #754 was present for this inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Resident Care (DORC), Associate Director of Resident Care (ADORC), Supervisor of Resident Care, Professional Standards Supervisor, Administrative Assistants, Program Support Services Manager, Food Service Supervisor, Registered Dietitian (RD), Placement Coordinator-North Simcoe Muskoka Local Health Integration Network (NSMLHIN), Manager of Home and Community Care NSMLHIN, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

The inspectors also toured three resident living areas, observed meal service, nourishment passes and medication administration; reviewed relevant clinical records, policies and procedures, schedules, investigation notes, high risk rounds reports; observed the provision of resident care, resident-staff interactions, and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **9 WN(s)**
- **5 VPC(s)**
- **3 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 failed to ensure that resident #001 was not neglected by the licensee or staff.

As per O.Reg 79/10 s.5. "neglect" means 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.

Resident #001's progress notes showed that resident #001 had a change in their health condition on three identified dates during a six day period.

Review of the home's 24 Hour/Daily High Risk Report that was sent by email from the night charge RN, at approximately 0600 hours daily, to the Administrator, Director of Resident Care, Associate Director of Resident Care, and Resident Care Supervisor included the change to resident #001's health condition for the three identified dates.

On an identified date RPN #115 reported to RN #105 the change in resident #001's health status. RN #105 shared that they did not assess resident #001 as it was the end of their shift but instructed the RPN to monitor resident #001 for any change.

RPN #125 shared that on an identified date they did call the RN and tell them about resident #001. RPN #125 shared that they were unaware that resident #001 had had a change in health condition on two previous days.

Eight days after the first documented change in resident #001's health condition, resident #001 was transferred to hospital.

During interviews with RPN #106, #125, RN #105 and #110 they shared that resident #001's substitute decision maker (SDM) and physician had not been

notified of the change in health condition.

DORC #101 shared that the physician and SDM should have been notified of resident #001's change in health condition. The physician was not notified and did not assess resident #001 during the identified dates.

Review of resident #001's paper work from the hospital showed that the resident had a health condition that required further interventions. Some identified tests done were unremarkable.

On an identified date resident #001 had an intervention done and after an identified period of time returned to Sunset Manor. On the day of return to Sunset Manor identified tests were repeated and remained unremarkable.

Review of resident #001's POC fluid intake documentation for a specified 10 day period, showed resident #001 refused fluids or was unavailable for fluids for 27/60 (45 per cent) of meal or nourishment passes.

On day nine of return from hospital resident #001 had the same identified tests repeated that were done on the day of return from hospital. These tests all showed significant changes. RN #130 documented a progress note that they received a call from physician #129 who stated they had a discussion with resident #001's SDM regarding the significant changes.

Record review of resident #001's progress notes, care plans, assessments and paper clinical records did not reveal any assessments or any interventions implemented to address low fluid intake for the identified period.

On an identified date, Inspector #155 observed resident #001 during a meal. It was noted that resident #001 took approximately 30 mls of fluid. During an interview RPN #106 shared that resident #001 was drinking okay and that the PSW staff had not reported anything to them regarding intake.

During interviews with RPN #106, #115, #125 and RN #110 they all were unaware of the process for monitoring fluid consumption and had not seen any clinical alerts for decreased fluid intake for residents.

RD #120 shared that they did not receive any referral for resident #001 during this ten day period for poor intake.

Review of resident #001's progress notes and nurse physician (NP) communication notes showed that physician #129 was not notified of resident #001's poor intake.

During interviews with ADORC #119 and DORC #101 they both were unaware that the clinical alerts did not trigger for resident #001's intake. DORC #101 was unaware of resident #001's fluid intake during the identified ten days and the change in resident #001's test results. They stated that the changes in laboratory values were concerning and that resident #001 should have been assessed and appropriately treated.

Resident #001 passed away on an identified date.

The licensee failed to ensure that resident #001 was not neglected by the staff or licensee when there was a pattern of inaction to address the resident change in status. There was no action taken to identify, access and implement interventions for resident #001's decreased intake. [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. 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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to immediately report the allegations of neglect for resident #001 and resident #005 and failed to provide the information upon which it was based to the Director.

On an identified date, the Director of Resident Care (DORC) #101 shared that they had become aware of a concern of alleged neglect regarding resident #001. The DORC #101 shared that a Critical Incident Report had not been submitted to the Director.

On an identified date an email was shared with Inspector #155 that was received by the Administrator #126, DORC #101, Assistant DORC #119 and Administrative Assistant #100 regarding allegations of neglect of resident #001 and resident #005.

Administrator #126 shared that there were no Critical Incident reports submitted to the Director regarding the allegations of neglect for resident #001 or resident #005.

The licensee failed to immediately report the allegations of neglect for resident #001and resident #005 immediately and failed to provide the information upon which it was based to the Director. [s. 24. (1)]

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 O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition care and hydration program included the development and implementation, in consultation with a registered dietitian who was a member of the staff of the home, of policies and procedures related to nutrition care and dietary services and hydration.

RD #120 stated they were unfamiliar with the County of Simcoe, Long Term Care Services, Dietary Manual; Policy Section-Nutrition and Hydration; Subject-Hydration Assessment and Management; Policy Number-DM G-45; Effective Date-June 2017 and the corresponding Hydration Assessment and Management Program Algorithm; Policy DM G-45-05.

RD #120 shared that they were not involved in the development and implementation of the policies and procedures related to nutrition care, dietary services and hydration. They said the policies were developed for the County of Simcoe by the Quality Assurance Steering Committee to which they were not a member.

The licensee failed to ensure that the nutrition care and hydration program included the development and implementation, in consultation with a registered dietitian who was a member of the staff of the home, of policies and procedures related to nutrition care and dietary services and hydration. [s. 68. (2) (a)]

2. The licensee failed to ensure that the nutrition care and hydration program identified any risks related to hydration status and failed to implement interventions to mitigate and manage those risks for residents #001, #002 and #006.

Resident #001 was assessed by RD #120 as having a fluid requirement of 10 glasses a day. Review of resident #001's fluid intake for an identified period of time showed resident #001's fluid intake averaged 3.7 glasses per day.

Resident #002 was assessed by RD #120 as having a fluid requirement of 6.5 glasses a day. Review of resident #002's fluid intake for an identified period of time showed resident #002's fluid intake averaged 3.6 glasses per day.

Resident #006 was assessed by RD #120 as having a fluid requirement of 6 glasses a day. Review of resident #006's fluid intake for an identified period of time showed resident #006's fluid intake averaged 3.8 glasses per day.

The County of Simcoe, Long Term Care Services, Nursing and Personal Care Policy Manual; Policy Section-Nutrition, Hydration and Dining; Subject-Monitoring Food and Fluid Intake; Policy Number-NPC H-30 with an effective date of November 2014 stated that all fluid would be electronically calculated and an alert report would automatically be sent to the registered staff after three days of decreased fluid intake.

The County of Simcoe, Long Term Care Services, Nursing and Personal Care Policy Manual; Policy Section-Nutrition, Hydration and Dining; Subject-Referral to Dietitian; Policy Number-NPC H-45 with an effective date of June 2015 stated that the RN or RPN would complete the electronic Dietitian Referral Form for a resident experiencing poor fluid intake over a 72-hour period and exhibited signs and symptoms of dehydration.

The County of Simcoe, Long Term Care Services, Dietary Manual; Policy Section-Nutrition and Hydration; Subject-Hydration Assessment and Management; Policy Number-DM G-45 with an effective date of June 2017 stated under the monitoring

section that all members of the interdisciplinary team were responsible for striving to ensure that residents met their fluid needs on a daily basis. Under the nursing interventions it stated:

-Any resident whose intake was less then 720 millilitres (mls) per day over a 72 hour period (4-180 ml glasses) or less than 50 per cent of the fluid requirements as calculated by the RD for greater than 3 days is assessed by the RN.
-"Encourage Fluids" measures will automatically be put in place by nursing staff for 72 hours which included being offered water hourly from a water jug at the bedside (1 jug equal to 1000 mls); will have initiated a "sip and go" routine for residents who are unable to consume the required additional fluids.
-If the issue was not resolved within 72 hours, registered nursing staff continue with the plan of care to "encourage fluids", inform the physician and initiate and complete a 3-day food and fluid intake record immediately. A Dietary Referral is completed and sent to the RD for assessment.
-Any resident whose intake was less than 1200 ml per 24 hours (6 glasses) or less than 50 per cent of the fluid requirements as calculated by the RD for 14 consecutive days was to be assessed by the RN. A plan of care was to be initiated by the registered staff involving the resident and family. A Dietary Referral is completed and sent to the RD for assessment.
-An automatic referral by the registered nursing staff to the RD was to occur after a change in health status requiring hospitalization and/or a resultant new diagnosis and or progression of a current diagnosis in order for the RD to reassess hydration status.

RPN #106 shared that the RPNs do not look at the POC documentation for food and fluids, that the dietary staff look at it on a quarterly basis or after they have received a referral.

RPN #115 shared they were not aware of any clinical alerts that triggered for decreased food or fluid intake. They also shared that a three-day food and fluid study would only be done if ordered by the RD.

RPN #125 shared that they did not get clinical alerts for decreased food and/or fluid intake, that they only got clinical alerts for pain and absence of bowel movements.

RN #110 said residents with decreased food and fluid intake would get discussed during high risk rounds which occurred weekly on each resident living area. They

were not aware of any clinical alerts that triggered in point click care for poor fluid intake.

RD #120 shared that they typically did not receive referrals for poor fluid intake. They became aware of any concerns with food or fluid intake by attending high risk rounds meetings, by doing dining observations, or by staff expressing concerns. RD #120 was not aware of the policies DM G-45 Hydration Assessment and Management, DM G-45-05 Hydration Assessment and Management Program Algorithm and NPC H-45 Referral to Dietitian. They also shared that they were the only one who reviewed the Point of Care documentation of fluid intake and clinical alerts were not being triggered for poor fluid intake.

Associate Director of Resident Care #119 and Director of Resident Care #101 shared that they were not aware of the policies DM G-45 Hydration Assessment and Management, DM G-45-05 Hydration Assessment and Management Program Algorithm and stated that the nursing staff likely had not seen them either. After review of resident #001's, #002's and #003's fluid intake they agreed that they did not consume adequate fluid and appropriate assessments and interventions should have been conducted.

The licensee failed to ensure that the nutrition care and hydration program identified any risks related to hydration status and failed to implement interventions to mitigate and manage those risks for residents #001, #002 and #006. [s. 68. (2) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 003

WN #4: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001's substitute decision maker (SDM) was provided the opportunity to participate fully in the development and implementation of the plan of care when they were not notified of resident #001's change in health status.

Resident #001's progress notes showed that they had a change in health status on three identified dates.

RPN #106, #125, RN #105 and #110 shared that the SDM was not notified of the change in health status on three identified dates.

DORC #101shared that the SDM should have been notified of resident #001's change in health condition.

The licensee failed to ensure that resident #001's SDM was provided the opportunity to participate fully in the development and implementation of the plan of care when they were not notified of resident #001's change in health status. [s.

6. (5)]

2. The licensee failed to ensure that resident #002 was provide care as specified in the plan of care.

Resident #002's physician orders stated that they were to have identified tests done annually.

The schedule showed that resident #002 was to have their identified tests completed during a specified month.

Resident #002's clinical paper chart contained their last identified test results done in 2017.

DORC #101 shared that the identified test results for resident #002 would be filed in resident #002's chart. They shared that if it was not there it was not done.

The licensee failed to ensure that resident #002 received their annual tests as per their plan of care. [s. 6. (7)]

3. The licensee failed to ensure that the provision of care set out in the plan of care was documented.

On an identified date, Point of Care documentation for fluids offered to residents #004, #007, #008, #010, #015 and #017 showed that PSW #113 had recorded these residents as being not available for the morning beverage nourishment pass on an identified resident living area.

PSW #113 shared that the residents had gone to programs/activities in the home.

Program Support Services Manager #121 shared that the program staff were to document the fluid and nourishments given to residents at the program/activity in POC.

Review of program attendance records was done with the Program Support Services Manager #121 and showed residents #004, #007, #008, #010, #015 and #017 attended an identified activity on a specified date. The Program Support Services Manager #121 acknowledged the program staff did not document the

fluids or nourishments consumed.

The licensee failed to ensure that the provision of fluids/nourishments consumed for residents #004, #007 #008, #010, #015 and #017 were documented. [s. 6. (9) 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 the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care; ensure that the care set out in the plan of care is provided to the resident as specified in the plan; and ensure that the provision of the care set out in the plan of care are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001 had an interdisciplinary team care conference to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision maker (SDM) annually.

Resident #001's assessments in point click care showed that a multidisciplinary care conference was held on an identified date.

Director of Resident Care #101 shared that there was no multidisciplinary care conference held annually for resident #001.

The licensee failed to ensure that resident #001 had a interdisciplinary team care conference to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision maker (SDM) annually. [s. 27. (1)]

2. The licensee failed to ensure that resident #005 had a interdisciplinary team care conference to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision maker (SDM) within six weeks of admission.

Resident #005's assessments in point click care showed that there were no multidisciplinary care conferences held since admission.

Administrative Assistant #100 shared that the expectation was that all residents receive a six-week admission conference even if the SDM did not attend.

The licensee failed to ensure that resident #005 had a interdisciplinary team care conference to discuss the plan of care and any other matters of importance to the resident and his or her SDM within six weeks of admission. [s. 27. (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 a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to offer resident #002, #004, #009, #011, #012, #013, #014, and #016 a between-meal beverage in the morning.

On an identified date a nourishment pass was observed on a resident living area. Resident #004 was observed to be sleeping in a chair outside of the entrance to the dining room. Resident #004 was not asked or offered any beverage during this nourishment pass.

Resident #004 shared that they did not recall being offered a beverage between breakfast and lunch. PSW #114 shared that they asked resident #004 if they wanted a beverage and they refused. This was not observed by Inspectors #155 and #754 who were observing the nourishment pass.

Resident #004's Point of Care documentation for fluids showed that resident #004 had refused the morning beverage on the identified date.

On an identified date, Point of Care documentation for fluids offered to the residents on a resident living area was reviewed. Residents #002, #009, #011, #012, #013, #014 and #016's record showed that PSW #113 had recorded these residents as being not available for the beverage nourishment pass.

PSW #113 shared that the residents were recorded as being not available for the beverage nourishment pass on the resident living area as they had gone to a program/activity.

Program Support Services Manager #121 shared that no beverages were served at this program/activity and the expectation was that when those residents returned to their living area they would be offered a beverage from the nourishment cart.

Review of program attendance records was done with the Program Support Services Manager #121. Review showed that residents #002, #009, #013 and #014 did not attend any program/activity on the identified date and residents #011, #012 and #016 attended a program/activity that did not offer nourishment.

The licensee failed to offer residents #002, #004, #009, #011, #012, #013, #014, and #016 a between-meal beverage in the morning. [s. 71. (3) (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 each resident is offered a minimum of, a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that proper techniques were used to assist resident #002 with eating that included safe positioning.

On an identified date, resident #002 was observed during the morning nourishment by Inspector #155 and #754. Resident #002 was repositioned by PSW #113. It was noted that resident #002 was still not positioned well for nourishment despite the re-positioning in the chair. PSW #113 then stood to the

right of resident #002 and gave them a drink of fluids.

Resident #002's care plan stated that resident #002 had to be positioned in a certain manner for eating or drinking and included use of specific devices.

On an identified date, during morning nourishment pass and during lunch, a device was not in place for resident #002 when observed by the Inspectors.

PSW #113 acknowledged that there was to be a device in place for resident #002 however, stated they could not recall if it was in place. They also shared that they had received education that they were to be seated when feeding residents during meals but was not aware the same applied when feeding residents their nourishment.

The licensee failed to ensure that proper techniques were used to assist resident #002 with eating that included safe positioning. [s. 73. (1) 10.]

2. The licensee failed to ensure that residents #002, #006 and #007 only received their meal when someone was available to provide the assistance required.

Resident #006 was observed sitting in the dining room for their lunch. It was noted that resident #006 was served their meal and slept during most of the meal. Resident #006 was removed from the dining room and no dessert was offered.

Resident #006's care plan stated that they needed physical assistance most times to feed themselves.

Resident #002 and #007 were observed being fed lunch by PSW #114. PSW #114 left the dining room leaving resident #002 and #007 with their meals on the table and no one available to provide assistance for a 14 minute period.

PSW #113 shared that there were not enough staff in the dining room for lunch. They shared that an RN and a program staff member usually came to assist with feeding but they did not assist on this date.

The licensee failed to ensure that residents #002, #006 and #007 only received their meal when someone was available to provide the assistance required. [s. 73. (2) (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 home has a dining and snack service that includes, at a minimum, the proper techniques to assist residents with eating, including safe positioning of residents who require assistance; and to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #005 received a medication in accordance with the directions for use specified by the prescriber.

The physician ordered that resident #005 was to receive a medication one hour before breakfast. The electronic medication administration record (eMAR) noted time for administration was 0700 hours.

Review of the Medication Administration Audit Report for resident #005 for an identified period of time was done. It showed that the medication was administered on five days at 0902 hours, at 0852 hours, at 1012 hours, at 0851 hours and at 0939 hours. There was no documentation as to why these doses were not administered at 0700 hours.

During an interview with the Director of Resident Care #101 they reviewed the Medication Administration Audit Report for resident #005. They shared that the expectation was that medications were to be administered as prescribed. If the registered staff were not able to administer accordingly then a progress note should be made.

The licensee failed to ensure that resident #005 received a medication in accordance with the directions for use specified by the prescriber on five identified days. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001 was assessed by a registered dietitian who was a member of the staff of the home when they returned from a leave of absence with an identified area of altered skin integrity.

Review of resident #001's clinical record showed that on an identified date, a Skin Assessment Tool was completed that stated the resident had an area of altered skin integrity.

Review of resident #001's clinical record in Point Click Care (PCC) under the assessment tab showed that there was no Referral to the Registered Dietitian on an identified date.

RD #120 shared that they did not get a referral for resident #001's area of altered skin integrity.

The licensee failed to ensure that resident #001 was assessed by a registered dietitian who was a member of the staff of the home when resident #001 returned from a leave of absence with an area of altered skin integrity. [s. 50. (2) (b) (iii)]

2. The licensee failed to ensure that resident #001 who was assessed on an identified date as having an area of altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

This is being issued as a Written Notification as it is new evidence that supports Compliance Order #002 issued May 30, 2019, inspection 2019_605213_0019, with a compliance due date of August 31, 2019.

Resident #001 returned from a leave of absence on an identified date and was assessed as having an area of altered skin integrity. There were no further Wound Assessment Tools completed for resident #001's area of altered skin integrity.

Upon review of resident #001's PCC clinical record, the Supervisor of Resident Care #102 stated that resident #001's area of altered skin integrity had not been reassessed.

The licensee failed to ensure that resident #001 who was assessed as having an area of altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [s. 50. (2) (b) (iv)]

Issued on this 19th day of September, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by SHARON PERRY (155) - (A1)
Inspection No. / No de l'inspection :	2019_773155_0010 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	009749-19 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 19, 2019(A1)
Licensee / Titulaire de permis :	Corporation of the County of Simcoe 1110 Highway 26, Midhurst, ON, L9X-1N6
LTC Home / Foyer de SLD :	Sunset Manor Home for Senior Citizens 49 Raglan Street, COLLINGWOOD, ON, L9Y-4X1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Martina Wynia

To Corporation of the County of Simcoe, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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 s. 19. (1) of the LTCHA.

Specifically, the licensee must:
a) Ensure that all residents of the home are protected from neglect by the licensee or staff.

b) Ensure that when there is a change in any resident's condition, staff provide the timely treatment, care, services and assistance required for the health, safety or well-being of the resident.

c) Ensure that when there is a change in any resident's condition the substitute decision maker (SDM)/ power of attorney (POA), family, physician, and any other appropriate health care staff are notified in a timely manner.

Grounds / Motifs :

1. As per O.Reg 79/10 s.5. "neglect" means 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.

Resident #001's progress notes showed that resident #001 had a change in their health condition on three identified dates during a six day period.

Review of the home's 24 Hour/Daily High Risk Report that was sent by email from the night charge RN, at approximately 0600 hours daily, to the Administrator, Director

of Resident Care, Associate Director of Resident Care, and Resident Care Supervisor included the change to resident #001's health condition for the three identified dates.

On an identified date RPN #115 reported to RN #105 the change in resident #001's health status. RN #105 shared that they did not assess resident #001 as it was the end of their shift but instructed the RPN to monitor resident #001 for any change.

RPN #125 shared that on an identified date they did call the RN and tell them about resident #001. RPN #125 shared that they were unaware that resident #001 had had a change in health condition on two previous days.

Eight days after the first documented change in resident #001's health condition, resident #001 was transferred to hospital.

During interviews with RPN #106, #125, RN #105 and #110 they shared that resident #001's substitute decision maker (SDM) and physician had not been notified of the change in health condition.

DORC #101 shared that the physician and SDM should have been notified of resident #001's change in health condition. The physician was not notified and did not assess resident #001 during the identified dates.

Review of resident #001's paper work from the hospital showed that the resident had a health condition that required further interventions. Some identified tests done were unremarkable.

On an identified date resident #001 had an intervention done and after an identified period of time returned to Sunset Manor. On the day of return to Sunset Manor identified tests were repeated and remained unremarkable.

Review of resident #001's POC fluid intake documentation for a specified 10 day period, showed resident #001 refused fluids or was unavailable for fluids for 27/60 (45 per cent) of meal or nourishment passes.

On day nine of return from hospital resident #001 had the same identified tests repeated that were done on the day of return from hospital. These tests all showed

significant changes. RN #130 documented a progress note that they received a call from physician #129 who stated they had a discussion with resident #001's SDM regarding the significant changes.

Record review of resident #001's progress notes, care plans, assessments and paper clinical records did not reveal any assessments or any interventions implemented to address low fluid intake for the identified period.

On an identified date, Inspector #155 observed resident #001 during a meal. It was noted that resident #001 took approximately 30 mls of fluid. During an interview RPN #106 shared that resident #001 was drinking okay and that the PSW staff had not reported anything to them regarding intake.

During interviews with RPN #106, #115, #125 and RN #110 they all were unaware of the process for monitoring fluid consumption and had not seen any clinical alerts for decreased fluid intake for residents.

RD #120 shared that they did not receive any referral for resident #001 during this ten day period for poor intake.

Review of resident #001's progress notes and nurse physician (NP) communication notes showed that physician #129 was not notified of resident #001's poor intake.

During interviews with ADORC #119 and DORC #101 they both were unaware that the clinical alerts did not trigger for resident #001's intake. DORC #101 was unaware of resident #001's fluid intake during the identified ten days and the change in resident #001's test results. They stated that the changes in laboratory values were concerning and that resident #001 should have been assessed and appropriately treated.

Resident #001 passed away on an identified date.

The licensee failed to ensure that resident #001 was not neglected by the staff or licensee when there was a pattern of inaction to address the resident change in status. There was no action taken to identify, access and implement interventions for resident #001's decreased intake.

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 1 isolated as it related to a single resident. The home had a level 3 history of 1 or more related non-compliance (NC) in the last 3 years that included a voluntary plan of correction (VPC) issued January 4, 2018 (2017_484646_0014).
(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 18, 2019

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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 or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee must be compliant with s. 24 (1) of the LTCHA.

Specifically, the licensee must ensure:
1. That any person who has reasonable grounds to suspect that the following has occurred or may occur, immediately report the suspicion and the information
upon which it was based to the Director:

a) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

2) That all Management of the home review the MOHLTC memo titled "Clarification of Mandatory and Critical Incident Reporting Requirements" dated August 31, 2018. A record of the completed review and Management sign off must be maintained at the home.

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

Grounds / Motifs :

1. On an identified date, the Director of Resident Care (DORC) #101 shared that they had become aware of a concern of alleged neglect regarding resident #001. The DORC #101 shared that a Critical Incident Report had not been submitted to the Director.

On an identified date an email was shared with Inspector #155 that was received by the Administrator #126, DORC #101, Assistant DORC #119 and Administrative Assistant #100 regarding allegations of neglect of resident #001 and resident #005.

Administrator #126 shared that there were no Critical Incident reports submitted to the Director regarding the allegations of neglect for resident #001 or resident #005.

The licensee failed to immediately report the allegations of neglect for resident #001and resident #005 immediately and failed to provide the information upon which it was based to the Director.

The severity of this issue was determined to be a level 2 as there was minimal harm to the residents. The scope of the issue was a level 3 as it related to two of two residents reviewed. The home had a level 3 history of 1 or more related non-compliance (NC) in the last 3 years that included a compliance order (CO) issued November 21, 2016 (2016_251512_0011). (155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,

(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;

(b) the identification of any risks related to nutrition care and dietary services and hydration;

(c) the implementation of interventions to mitigate and manage those risks;

(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

(e) a weight monitoring system to measure and record with respect to each resident,

(i) weight on admission and monthly thereafter, and

(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee must be compliant with O.Reg 79/10 s. 68 (2).

Specifically, the licensee must:
a) Review the policies and procedures relating to nutrition care, dietary services and hydration with a registered dietitian who is a member of the staff of Sunset Manor.

b) Provide education to all direct care staff regarding the following policies/procedures:
i) Hydration Assessment and Management-policy number DM G-45,
ii) Hydration Assessment and Management Program Algorithm-policy number DM G-45-05,
iii) Referral to Dietitian- policy number NPC H-45,
iv) Food Intake Study- policy NPC H-05,
v) Monitoring Food and Fluid Intake- policy NPC H-30, and
vi) any other relevant policies.
The education provided shall be documented and include the date and identity of the staff educated. These records will be kept in the home.

c) Ensure that resident #002, #006 and any other residents have been assessed for any risks related to nutrition care, dietary services and hydration and that interventions are implemented to mitigate and manage the risks.

d) Develop and implement a written plan/audit to ensure that residents with poor fluid intake are identified and appropriate interventions and referrals are utilized to mitigate risks for resident #002, #006 and any other residents. The audit shall be documented and include the date and the identity of the staff who completed the audits. The audits shall be kept in the home.

Grounds / Motifs :

1. RD #120 stated they were unfamiliar with the County of Simcoe, Long Term Care Services, Dietary Manual; Policy Section-Nutrition and Hydration; Subject-Hydration Assessment and Management; Policy Number-DM G-45; Effective Date-June 2017 and the corresponding Hydration Assessment and Management Program Algorithm; Policy DM G-45-05.

RD #120 shared that they were not involved in the development and implementation of the policies and procedures related to nutrition care, dietary services and hydration. They said the policies were developed for the County of Simcoe by the Quality Assurance Steering Committee to which they were not a member.

The licensee failed to ensure that the nutrition care and hydration program included the development and implementation, in consultation with a registered dietitian who was a member of the staff of the home, of policies and procedures related to nutrition care and dietary services and hydration. [s. 68. (2) (a)]
(155)

2. The licensee failed to ensure that the nutrition care and hydration program identified any risks related to hydration status and failed to implement interventions to mitigate and manage those risks for residents #001, #002 and #006.

Resident #001 was assessed by RD #120 as having a fluid requirement of 10 glasses a day. Review of resident #001's fluid intake for an identified period of time showed resident #001's fluid intake averaged 3.7 glasses per day.

Resident #002 was assessed by RD #120 as having a fluid requirement of 6.5 glasses a day. Review of resident #002's fluid intake for an identified period of time showed resident #002's fluid intake averaged 3.6 glasses per day.

Resident #006 was assessed by RD #120 as having a fluid requirement of 6 glasses a day. Review of resident #006's fluid intake for an identified period of time showed resident #006's fluid intake averaged 3.8 glasses per day.

The County of Simcoe, Long Term Care Services, Nursing and Personal Care Policy Manual; Policy Section-Nutrition, Hydration and Dining; Subject-Monitoring Food and Fluid Intake; Policy Number-NPC H-30 with an effective date of November 2014 stated that all fluid would be electronically calculated and an alert report would automatically be sent to the registered staff after three days of decreased fluid intake.

The County of Simcoe, Long Term Care Services, Nursing and Personal Care Policy Manual; Policy Section-Nutrition, Hydration and Dining; Subject-Referral to Dietitian; Policy Number-NPC H-45 with an effective date of June 2015 stated that the RN or RPN would complete the electronic Dietitian Referral Form for a resident experiencing poor fluid intake over a 72-hour period and exhibited signs and symptoms of dehydration.

The County of Simcoe, Long Term Care Services, Dietary Manual; Policy Section-Nutrition and Hydration; Subject-Hydration Assessment and Management; Policy Number-DM G-45 with an effective date of June 2017 stated under the monitoring section that all members of the interdisciplinary team were responsible for striving to ensure that residents met their fluid needs on a daily basis. Under the nursing interventions it stated:

-Any resident whose intake was less then 720 millilitres (mls) per day over a 72 hour period (4-180 ml glasses) or less than 50 per cent of the fluid requirements as calculated by the RD for greater than 3 days is assessed by the RN.
-"Encourage Fluids" measures will automatically be put in place by nursing staff for 72 hours which included being offered water hourly from a water jug at the bedside (1 jug equal to 1000 mls); will have initiated a "sip and go" routine for residents who are unable to consume the required additional fluids.
-If the issue was not resolved within 72 hours, registered nursing staff continue with the plan of care to "encourage fluids", inform the physician and initiate and complete a 3-day food and fluid intake record immediately. A Dietary Referral is completed and sent to the RD for assessment.
-Any resident whose intake was less than 1200 ml per 24 hours (6 glasses) or less than 50 per cent of the fluid requirements as calculated by the RD for 14 consecutive days was to be assessed by the RN. A plan of care was to be initiated by the registered staff involving the resident and family. A Dietary Referral is completed and sent to the RD for assessment.
-An automatic referral by the registered nursing staff to the RD was to occur after a change in health status requiring hospitalization and/or a resultant new diagnosis and or progression of a current diagnosis in order for the RD to reassess hydration status.

RPN #106 shared that the RPNs do not look at the POC documentation for food and fluids, that the dietary staff look at it on a quarterly basis or after they have received a referral.

RPN #115 shared they were not aware of any clinical alerts that triggered for decreased food or fluid intake. They also shared that a three-day food and fluid study would only be done if ordered by the RD.

RPN #125 shared that they did not get clinical alerts for decreased food and/or fluid intake, that they only got clinical alerts for pain and absence of bowel movements.

RN #110 said residents with decreased food and fluid intake would get discussed during high risk rounds which occurred weekly on each resident living area. They were not aware of any clinical alerts that triggered in point click care for poor fluid intake.

RD #120 shared that they typically did not receive referrals for poor fluid intake. They became aware of any concerns with food or fluid intake by attending high risk rounds meetings, by doing dining observations, or by staff expressing concerns. RD #120 was not aware of the policies DM G-45 Hydration Assessment and Management, DM G-45-05 Hydration Assessment and Management Program Algorithm and NPC H-45 Referral to Dietitian. They also shared that they were the only one who reviewed the Point of Care documentation of fluid intake and clinical alerts were not being triggered for poor fluid intake.

Associate Director of Resident Care #119 and Director of Resident Care #101 shared that they were not aware of the policies DM G-45 Hydration Assessment and Management, DM G-45-05 Hydration Assessment and Management Program Algorithm and stated that the nursing staff likely had not seen them either. After review of resident #001's, #002's and #003's fluid intake they agreed that they did not consume adequate fluid and appropriate assessments and interventions should have been conducted.

The licensee failed to ensure that the nutrition care and hydration program identified any risks related to hydration status and failed to implement interventions to mitigate and manage those risks for residents #001, #002 and #006.

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 3 as it related to all residents in the home. The home had a level 2 history as they had previous unrelated areas of non-compliance. (155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 09, 2019(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 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:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 19th day of September, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by SHARON PERRY (155) - (A1)

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

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